Symposium Report

The Quality of Life in Old Age: Views from Various Cultural Perspectives

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An Affiliate of
Mount Sinai School of Medicine

Sponsored by
The International Longevity Center-USA and
The Mission of the Dominican Republic to the UN

June 6, 1997
Dag Hammarksjold Auditorium
United Nations

The International Longevity Center–USA (ILC–USA) is a not-for-profit, nonpartisan research, education and policy organization whose mission is to help individuals and societies address longevity and population aging in positive and productive ways, and highlight older people's productivity and contributions to their families and society as a whole.

The organization is part of a multinational research and education consortium, which includes centers in the U.S., Japan, Great Britain, France and the Dominican Republic. These centers work both autonomously and collaboratively to study how greater life expectancy and increased proportions of older people impact nations around the world.

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Introduction

Robert N. Butler, MD, ILC-USA

The International Longevity Center regards quality of life as a priority. It is not enough for people to live long. They should also live well. But quality of life is a difficult concept to define and measure. Although there are universal aspects recognized by all societies, there are also cultural nuances worthy of note and perhaps emulation.

To help sort through these important issues, the United Nations Quality of Life Symposium brought together the leaders of the four ILCs, as well as a representative of the Dominican Republic,* who provided a voice from the Third World. Readers will certainly notice similarities between these international perspectives, but profound differences will also be apparent.

Alexandre Sidorenko, the head of the Ageing Program of the United Nations, reminds us that 1999 marks the United Nations Year of Older Persons. This symposium is part of the continuing education, which will help all 185-member nations of the United Nations work to improve the material well-being and quality of life of their older citizens.

June, 1997

* *The Dominican Republic became a sister member of the ILC in 1998.*

Program

SYMPOSIUM
Quality of Life in Old Age:
A View from Various Cultural Perspectives
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Shigeo Morioka
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COMMENTARY
Charlotte Muller, PhD
Associate Director for Economics, ILC-USA

COMMENTARY AND QUESTIONS FROM THE AUDIENCE

CLOSING COMMENTS
Alexandre Sidorenko
Officer in Charge of the Ageing Program,
Division of Social Policy and Development,
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Charlotte Muller, PhD

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Robert N. Butler, MD

Shigeo Morioka

Longevity and Quality of Life in Our Third World

Ambassador Julia T. Alvarez
Mission of the Dominican Republic to the United Nations

I would like to begin by thanking the International Longevity Center for hosting this symposium. The quality of the attendees suggests that we are going to hear some insightful and interesting points of view on aging and the quality of life. I trust that my modest contribution will not create any problem regarding quality control.

I believe that next month is Older Americans Month. Coincidentally, I hope, it is also National Arthritis Month. As the sole presenter from our Third World, I can assure you that joint diseases are international in scope. Equally worldwide is population aging. But the social setting for this phenomenon varies so much as to make "quality of life" a relative term when applied to aging.

Aging, of course, is nowhere an end in itself. Our goal is to add a maximum of living to the years that modern medicine has added to life—to live well, as well as to live long. I think that's a reasonable definition of quality of life. And certainly the maintenance of good health into the later years is central to this goal.

In our Third World, the battle for better health and a better life for our elders will be fought in the social and political rather than the strictly biological and medical realms; not in the laboratory and hospital, but in those places of power that allocate resources and devise social policies; in the consciousness of the people; in legislatures, banks, and universities.

Increasingly, over the next two decades, when we speak about world population aging, we will be speaking about our Third World. The United Nations projects that the population of those age 60 and over in our Third World will grow at a rate more than twice that in the industrially developed countries. Among very old people, those 80 years of age and over, who are more likely to need assistance, the true revolution also will occur in the Third World. Between 1980 and 2020, the number of octogenarians will double in the more developed regions, rising in absolute numbers from 22 to 46 million persons. However, during this period, in our developing countries, the number of people in this age group will increase by a factor of five, from 12 million to 64 million persons. Most very old persons will be living in developing countries.

In the developing nations, "problems" of aging are already largely problems of poverty. You won't find us worrying about how leisure time will affect one's mental health, whether we should opt for HMOs or individual choice of physicians, nursing homes or home care. Where I come from, "quality of life" begins—and often ends, in more

ways than one—with what is on the dinner table. Too often there is very little to be found there.

In other words, in our Third World, the first and foremost principle of longevity and health is: if you want to age, you have to eat.

Gender is also a central issue. Here, as in the developed nations, the face of aging is, and most often will be, female.

The United Nations projects that on top of increases in life expectancy since the 1960s, women in Western Asia and Africa can expect gains of seven to ten years by the beginning of the twenty first century, and then five to eight years over the following two decades. Eastern Asia and Latin America should see smaller increases.

The absolute numbers of older women in the population will be imposing. According to the United Nations, there were 208 million women over age sixty in 1985 worldwide, half of whom lived in the Third World. Projections put this figure at 604 million by 2025, with seventy percent in the Third World. As things now stand, a full seventy percent of these older Third World women will be living in rural poverty.

An overwhelming majority of older women in developing countries now are illiterate, poor, socially dependent, and lack personal resources to cope with changing social conditions. Many have suffered throughout their lives from poor health care, malnutrition, illiteracy and low social status simply because they were born female. Where resources are scarce, the tendency has been for families to give priority to the health, nutrition and education of boys and men, for they are seen as the productive part of the family. For these women, preventive medicine is already an irrevocably missed opportunity.

With the increased migration from the countryside and the incorporation of younger women into the labor market, the nuclear family is replacing the extended family. The meaning of kinship is changing. The support that older women might have expected from this source in the past must now, and in the future, come from elsewhere.

The specific availability of health care facilities for aging women and men is also problematic. For example, in the Dominican Republic there are now about 400,000 people over the age of 60. We have one hospital geriatric ward. It has all of ten beds. That's it.

In my country, it is hard to find a hospital bed for a sick older person. Hospitals are reluctant to accept such patients, for once admitted, it is hard to discharge them. They don't want to leave—and why should they? In the hospital they have a bed, meals and a level of comfort they don't have at home—if they have a home.The hospital thus becomes a place in which to find, not just preserve, quality of life.

Given what I have said so far, can you imagine what sort of "quality of life" Third World older persons can expect in the future? You would think that policy makers would be working into the night planning for this new age of aging. Unfortunately, this is not the case.

Our governments and social welfare institutions are swamped by the problems of present poverty. The here and now commands all their energy and attention. They see looking ahead as an unaffordable luxury.

For the most part, social security in developing nations is not a problem. It is a fantasy. Our equivalent to Medicare is too often simply thin air, with not even the wisp of an outline of some kind of medical insurance for older people.

Should we, then, simply throw up our arms in despair and let nature take its brutal course? Surely not, but we had better be inventive in order to do what we need to do with what we have. Our prescription for better health had better involve that which is affordable, attainable and workable. Let me sketch, very briefly, two broad approaches that will help us begin to cope with the reality of the demographic upheaval that will soon shake the old social order in so many nations. I offer them as, perhaps, points of departure for our later discussions.

The most basic tool for good health we can provide to Third World elders is the opportunity to make at least a modest income, not because they need to keep active—a value in the developed world—but because they first need to keep eating. How might we do this? There are, of course, specific projects geared toward this end. In the Dominican Republic, for example, we have brought retired teachers in rural areas back into the classroom, creating income for them and a much-needed educational resource for their young pupils. In the process, elders interact with students in a positive way, creating constructive images of older people. Hopefully, such initiatives will help to decrease the chances of future conflict between the generations over scarce resources.

We have also mounted demonstration projects involving hydroponic farming, which is also adaptable to people of all ages with disabilities. In each case, local groups have worked with international non-governmental organizations to create a matrix of skills, experience and funding that will serve us well in the future.

On a larger scale, older persons, especially people in their 60s and 70s, need access to small amounts of capital so that they may start modest, even part-time businesses. Two months ago, a worldwide conference on microcredit, as this movement has become known, was held in Washington. The microcredit approach is appropriate in our Third World because it allows us to do a lot with a little.

The medical counterpart of microcredit, to maintain the health of aging populations in our Third World, is the selective use of traditional and folk medicine alongside modern procedures, and the encouragement of medical self-help, whenever possible, among older persons. We can't have modern medical centers, or even miniature versions of them. But we can make maximum use of the tools that are all around us. For example, herbal medicines, and greater utilization of stress reduction techniques as preventive medicine, are likely to prove useful in promoting the physical well-being of older people at an affordable price.

Given the limited resources available, self-help and mutual aid should also be of paramount importance in our Third World medical care of the aged. This means physicians' assistants—ideally, older people themselves starting second careers—replacing doctors wherever possible. In our developing nations, this is not extraordinary. Midwives, for example, have long been important there out of necessity. We don't have enough doctors to go around, so paraprofessional medical care is the norm.

I have concentrated on the different needs of, and resources available in, the developed and developing nations. But these contrasts can be constructive. Let us be aware of, celebrate, and mine what is useful in our differences. Let us think of social contrasts raised by different cultural and economic contexts not as an unbridgeable gap but rather as a quarry, rich in potential social inventiveness. They are a challenge to our ability to learn from each other. After all, microcredit originated in our Third World, with the Grameen Bank of Bangladesh. Now it's being adapted as a social resource in much richer nations.

We will need this two-way flow of information, invention, and adaptation because, in the aging of worldwide populations, we face something that is literally new under the sun. We haven't been there before. It is a new phenomenon in world history. So we are all pioneers, all explorers, pushing into a frontier that offers both peril and promise, and we can't do it alone.

In that spirit, I trust that our discussion will be infused with those very qualities of social inventiveness and mutual aid, the presence and application of which will do much to determine what sort of quality of life so many of the world's elders can expect in the new century.

Toward a Definition of Quality of Life for an Aging Society

Robert N. Butler, MD, ILC-USA

THE INDIVIDUAL AND SOCIETY

Let us begin our inquiry into the complex subject of quality of life with the question, "What do most people want?" Most of all, they want love, meaningful work, safety and security, energy and health, power, fame and wealth to varying degrees, a long life of high quality, and a society that supports these goals. There are no single, simple definitions or measures of quality of life. Subjectivity and nuance are essential. In light of the fact that people are living longer, quality of life becomes much more important. It is a valid goal in medicine and in life.

How, then, is quality of life to be measured? Here, societal and scientific perspectives will necessarily lead to philosophy and to cultural and personal values. Quality of life is an amorphous notion, constantly changing. The definition of quality of life varies in different historical periods, cultures, and stages of life. People with many interests enjoy more of life's pleasures. But the supportive structures and attitudes of society also affect the individual's quality of life in perception and reality. The question: How is quality of life to be evaluated? It is an exceedingly difficult one to answer throughout life, and it may also be dangerous under certain circumstances. One's personal definition of quality of life is, and should be, highly individual and subjective, and quantifying someone else's quality of life should be done with great care. It is all too easy for governments and doctors, for example, to declare someone unworthy of life itself because they believe the individual has a poor quality of life. We have seen this occur in various countries at different points in history and it happens today in the United States and elsewhere.

The popular view is that no one wants to live long if he or she is no longer able to enjoy life. Public concern over quality of life has increased with the advent of aggressive surgical and chemotherapeutic approaches to cancer and various technologies to deal with other diseases and trauma. People are ambivalent. They want to do everything possible to survive illness and trauma but often become upset over the means employed. Undoubtedly, this is why so much of the literature relating to quality of life concerns outcomes from treatment of conditions such as angina, depression, cancer, and stroke. Of course, health is a major constituent of quality of life, but not the only one. One's genetic constitution, birth and childhood, societal conditions, as well as gender and race, also contribute to quality of life and basic survival. The scholarly literature emphasizes health and material status, which are relatively easier to measure. But neither fully encompasses, defines, or equals quality of life. For example, people of limited means can enjoy a high quality of life.

That is why it is best to first define quality of life globally as an overall sense of well-being and, separately, evaluate its many components or aspects.

It is also necessary to bear in mind other concerns over quality of life in older populations. People wonder, can we afford the growing numbers of older persons? Will population aging cause economic stagnation? Will there be increasing intergenerational conflicts? These concerns need not lead to a reduction in the quality of life—quite the contrary. For the majority can now expect to enjoy a long life and the generations can build richer, collaborative relationships. An older person's quality of life improves when she or he is productive and is not treated as a burden by society.

Defining Quality of Life

I suggest a list of various aspects of quality of life (see Table 1) that apply throughout life but become more acute with the ebbing of one's life. This list is neither intended to be exhaustive nor given in order of importance.

Some of the aspects of quality of life are obvious and basic such as physical, financial, personal, and social well-being. These categories include possession of intellectual ability; the capacity to perform activities of daily living; freedom from pain and suffering; preservation of the senses and sensuality; a social support system; an adequate financial base; mastery over one's life (independence, autonomy, and choice); a purpose outside of oneself that offers a sense of usefulness; and some degree of happiness and morale. Quality of life also comprises freedom, legal protection, and human rights. Far from being immutable, even these basic elements are relative and their importance varies widely according to personality and circumstances. For example, certain personality characteristics can be adaptive or transcend the most profound physical and mental pathology. This explains why some persons even with severe dementia, with paralysis, or living a limited life in a nursing home still enjoy their lives and consider them of relative high quality. Personality characteristics help us understand how a Stephen Hawking continues to contribute to physics and why the family of an end-stage dementia patient may insist on preserving the patient's life in spite of inevitable decline.

Other aspects of quality of life, such as possession of a sense of purpose, moral well-being and spirituality, are more complex, subjective and relative. Quality of life may mean very different things to different individuals. For one, it may mean having a rich network of friendships. For another, it may mean being alone and enjoying music in solitude. We must be very careful in our judgments about this elusive concept, which goes to the core of one's being, involving the most personal and intimate aspects of one's life.

Perhaps the most complex areas of quality of life are life satisfaction and coming to terms with one's quality of life at the end of life. Elemental pleasure, that is, the ability to enjoy the moment, is usually easy in a favorable childhood, but not easy to maintain or rediscover in adulthood.

The classic and simplest equivalent of quality of life is happiness, which is usually regarded as something under one's own control. However, increasingly, American psychologists regard happiness as largely determined by genes, very much like the set-point concept of weight control. Wealth, education, marriage, and family have only marginal and transient effects upon levels of happiness. Losses and trauma can have profound effects and lead to clinical depression despite the set-point. On the other hand, Dr. David T. Lykken, a behavioral geneticist, proposes that "a 'steady diet' of simple pleasures" will keep one above one's set-point.[1]

Length and Quality of Life

The length of life and quality of that life are certainly intertwined. For example, in the last 30 years, according to Jacob Feldman of the National Center for Health Statistics, there has been an increase in the amount of disability for each decade of life, resulting in the growth of "medicated survival" in the later years.[2] The fastest growing group of "medicated survivors" consists of those 85 years of age and older. In this age group, we see not only new pathologies but also the accumulated effects of lifelong health habits (e.g., alcohol consumption, smoking, etc.), chronic diseases, and exposure to environmental factors, such as occupational hazards. Therefore, it would seem that the longer one lives, the more one's quality of life may be compromised. However, recent data from Kenneth Manton and his colleagues at the Duke University Center for Demographic Studies shows that, while the number of disabled "medicated survivors" is increasing, the disability rate is actually declining.[3]

To qualify the relationship between health and quality of life, D. F. Sullivan introduced the notion of "disability-free life expectancy" at the National Center for Health Statistics in 1971. Then came the notion of "active life expectancy" and still later, the concept of "health span" from the Surgeon General's office. Others use the term "quality time." All of these terms have been defined using different criteria, some overlapping, but all useful. In addition, a variety of measurements have been developed in connection with the basic aspects of quality of life: Sidney Katz's activities of daily living; and Robert Havighurst's and Bernice Neugarten's life satisfaction. Moreover, a variety of rating systems with regard to specific disease states such as cardiac disability and depression have been created.

A high quality of life can extend the length of life. Having goals, purpose, and structure in one's life are associated with a longer life. In the National Institute of Mental Health studies in the 1950s and 1960s of healthy community residents, some 15 percent of older people were consciously frightened of death, and for them just being alive meant having quality of life.[4] On the other hand, there were those who had a distinct dread of longevity and fear of having to live a long time in a debilitated state. It is significant, therefore, that when the Research on Aging Act was passed by Congress, creating the National Institute on Aging, the language of the Act made it clear that the goal must be the preservation and continuation of the vigorous, healthy, middle-period of life, not the pursuit of extended length of life for its own sake.

The new interventionist gerontology, which contributes to quality of life, has three components: (1) revision of the stereotypes and myths about aging, such as inevitable senility, absence of sexuality, lack of productivity and institutionalization in old age; (2) better appreciation of the underlying mechanisms that account for how and why biological systems grow old; and (3) actual and potential preventive and therapeutic interventions. Further research should be focused on hearing, vision and mental function, which are so critical to quality of life, to augment the already useful strategies to preserve these functions.

In keeping with the interventionist aspect of the new gerontology, it would be wise for individuals to confront the quality of their own aging and mortality. They should write a detailed letter of instruction that spells out how they would like their quality of life to be maintained under changing conditions, especially in the case of diminished capacity to make decisions. In addition, one may wish to write a letter or journal, or to dictate on tape for one's family, friends, and

others one's hopes and reminiscences. An evaluative life review could be personally therapeutic and enlightening to one's family. As life reaches its end, personal resolution of conflict and reconciliation with estranged friends and loved ones are needed. These steps can dramatically enhance one's quality of life.

Society and Government

As individuals, we can help enhance the quality of life for older and disabled people and people of all ages by influencing government and society in a variety of ways. The late U. S. Congressman Claude Pepper was quoted as saying, "What have I done today to lighten the burden of those who suffer?" Adjusting our environment to the requirements of different age groups is one way society can enhance quality of life. Something as basic as changing the timing of traffic lights, for example, would help create a safer environment for older people, pregnant mothers, injured teenagers, or anyone else who needs more time to cross the street safely. As another example, underfoot treads found in train stations in Japan and other countries help guide people with limited vision safely on and off trains.

Socioeconomic factors decisively influence quality of life. Beyond our individual control are such vicissitudes of life as unexpected illness and social and economic disasters such as the economic depression of the 1930s and inflation of the mid-1960s. Having a social safety net is society's way of helping people cope with such problems. Financial strength is clearly not the only factor influencing quality of life. In their remarkably self-critical way, the Japanese have noted that Japan has become a "rich country with poor people"—poor because the Japanese lack the infrastructure and living environment necessary for high quality of life.

Very special issues affect women that can enhance or diminish their quality of life. In addition to being more at risk for economic difficulties than men, women must also cope with the care giving burdens that fall primarily on them. Care giving, while providing a certain amount of satisfaction, can be very stressful and compromise quality of life. Stress can, in fact, be a contributing factor in the development of disease. Enjoying a high quality of daily life, then, depends greatly upon having some leisure time and freedom from personal and societal stress. Society can help reduce such stress by providing some measure of protection against the vagaries of life that are beyond an individual's control.

The Arts and Humanities

Society's ability to foster quality of life would follow from the better understanding of human development throughout the life course. Quality of life is affected by education across the life cycle, and leisure time for people to build upon their own creativity and enjoy that of others. Despite advantages, however, many people do not know what to do with themselves when they grow old. Continuing education is one source of satisfaction. The New School for Social Research in New York City, for example, has had a unique educational enterprise, the Institute for Retired Professionals (IRP) since 1958, and Elderhostel and various educational institutions offer travel and educational opportunities to older persons.

Conclusion

We do not yet have a philosophy of longevity and aging in Western civilization that would help us deal with this new added period of life and its quality. Perhaps that is because in the past philosophers were not pressed to address this topic since relatively few people survived into old

age. Writings on the philosophy of aging include Ecclesiastes, Cicero's "De Senectute", some of Montaigne's contemplations, Shakespeare's stages of life, and George Bernard Shaw's remarkable linked plays "Back to Methuselah." Beyond these, however, there is relatively little on the subject. More than ever, we need guidebooks to help us build upon our inner resources and deal productively with late life. Quality of life is not a passive occurrence, but a process and goal toward which we must actively strive.

TABLE 1.
QUALITY OF LIFE INDICATORS

Physical Well-Being
- Energy and function
- Sexuality
- Quality health care
- Freedom from pain
- Preservation of senses (e.g., vision and hearing)
- Adequate rest and sleep

Financial and Material Well-Being
- Financial security and independence
- Income from a variety of sources
- Having a job

Personal Well-Being
- Mental health and happiness
- Self-esteem/dignity
- Identity, continuing growth
- Body image/appearance
- Memory
- Control over one's life/independence
- Dignity
- Morale
- Freedom from excessive stress
- Adaptiveness
- Choice—opportunity
- Education
- Love

Social Well-Being
- Family, friendship, social network and support system

Life Satisfaction
- Reminiscence and life review
- Accomplishments
- Full life
- Creativity
- Serenity

Purposeful Well-Being
- Contribution to others/altruism
- Productive aging
- Knowledge (truth)

Aesthetic Well-Being
- Exposure to music, arts, humanities (beauty)
- Leisure time

Joyfulness
- Pleasures, big and small
- Food—recreation—travel
- Adventure—excitement
- Merriment

Moral Well-Being
- Clear conscience (goodness)

Enjoyment of One's Lifetime
- Feeling that "It has been a good time to be alive."

Spirituality
- Beyond self
- Personal beliefs

Living in the Present
- Elementality, simplicity
- Freedom from preoccupation with past and future

End of Life
- Quality of dying
- Sense of control
- Quality of care (pain and suffering)

Quality of Life and the Longevity Revolution: A French Perspective

Françoise Forette, MD, ILC-France

France, like all western countries, is facing an extraordinary longevity revolution. The mean life expectancy is now 73 years for men and 82 years for women. Around 20 percent of the population is over sixty years of age. In 2015, 40 percent of the population will be over fifty. Nowadays, only one-third of the population over fifty is still working. Projections from this suggest that in 2015, 30 percent of the population will have to financially support the 70 percent of the population which will include not yet active younger persons and retired or unemployed older persons.

The ethical question we have to address is: How can we maintain equity and promote the quality of life of all generations living together in this country?

The main determinants of quality of life for people over sixty are satisfactory health status, financial autonomy, family links, positive image, social role, and personal responsibility. The ethical challenge of our societies is to guarantee that economic pressure does not compromise the rights of this expanding population. Among the areas that must be addressed are the following: highly skilled medical care, including preventive medicine; access to work or fair retirement pensions; political influence; a social role including access to culture; and entitlement to a productive life.

All medical data demonstrate that a vast majority of the aging population is going to grow older in health, autonomy and productivity.

On the other hand, two critical issues must be considered: First, a minority of older people remain at risk for chronic diseases leading to a devastating dependence, although research and prevention should progressively decrease its proportion.

Second, there are growing numbers of persons who happily reach a very advanced age. These nonagenarians and centenarians, although often healthy, remain a frail population that needs assistance.

Frail old persons present challenges that need innovative solutions. Still, their number is small when compared to the increasing number of dynamic, healthy and productively aging individuals.

Quality of life related to health status and highly skilled medical care

The compression of morbidity into the last few years of life is no longer out of reach. The disability-free life expectancy is increasing more rapidly than the mean life expectancy.

The self-reported prevalent morbidity is still high in older persons. A recent French study of a representative sample of people 65 and over found that the mean number of self-reported diseases is 7.6 per person. The number is significantly higher in women (8.4 per person) than in men (6.8 per person).[5]

But a declining incidence of most conditions leading to disability and a decrease in institutionalization are observed in Europe as well as in the US.[6] Stroke is a very good example of a disabling disease that is decreasing in frequency due to a number of factors. It is clear that better control of the identified risk factors for stroke will further strengthen this trend. Community control has been highly effective in Europe in the North Karelia Project.[7]

Health promotion and disease prevention measures can help reduce risk factors for other diseases as well. Besides cardiovascular diseases, osteoporosis and bone fractures are a leading cause of death, disability and institutionalization. In women, one of the most effective preventive measures against osteoporosis is estrogen replacement therapy after menopause. But in France, fewer than ten percent of post-menopausal women are on estrogen replacement therapy. However, among women who have recently passed through menopause, 30 percent are on estrogen replacement therapy. Progress has clearly been made, but tremendous work remains to be done. As underlined by Manton, "disease prevention, a delay in age at onset, or a disease cure all can cause morbidity prevalence to decline…For example, slowing the development of cataracts and increasing the age at which they appear by 10 years, would reduce their prevalence by half…"[8]

The last point concerns the links between quality of life health status, and highly skilled medical care. It is well known that health status depends on various factors: genetic and biological factors, socio-economic level, education, social security systems, etc.; but it also has been proven that access to health care and quality of care are major determinants for improving the health status of older people, particularly the frail aged. Specific geriatric programs have been evaluated in the US and a number of other countries. Most of these studies have confirmed that comprehensive geriatric assessment, geriatric evaluation and management units, and departments or divisions of geriatric medicine not only decrease early mortality, but also improve the functional status of frail older persons, reduce the frequency of discharge to long-term care institutions, and decrease the rate of hospital readmission. This is probably the best way to promote quality of life.

Quality of life related to economic issues

Access to work or fair retirement pensions is another key to quality of life. The present economic crisis has hit an increasing number of aging workers. Retirement is therefore imposed earlier and on people who do not always want it. This devaluation fundamentally contradicts the image of an active and new beginning in life when one ages.

The income of older citizens has nevertheless greatly progressed in France for the past 20 years. In the seventies, it was 20 percent lower than that of younger populations. In 1996, the situation is reversed. The financial resources of the older population are at least 5 percent higher than those of the younger population. However, that is the case only for the "young" aging population, or those up to 75 years old. Around 10 percent of the older population lives on social welfare. Most of them are widowed, single or divorced, and over 75 years of age. But, as a whole, older people are wealthy.[9]

Economic studies always focus their interest on the "cost" of the aging process. Now, with the emergence of a large, dynamic, healthy and wealthy older population we have to look at the other side of the same question. That is, we must determine the contribution of the aged to the economies of our countries. Money is often transferred from the eldest to the youngest. Elders participate more than ever in the economic cycle due to their increase in number and in purchasing power. As a whole, it is clear that older people still represent an important part of the economic system and probably a specific "market."
Even frail older persons contribute to the economy. When they are dependent and need assistance, they generate new jobs in European countries where unemployment is a devastating problem. If we succeed in emphasizing this important economic role of older citizens, it is going to change the image of aging radically.

Quality of life related to social role and family

Transfers from one generation to another are not limited to monetary transfers. The ILC study, "Legacy and Responsibility Among Generations," analyzes what philosophical or moral values the generations want to pass on, such as family ties, compassion, religious spirit, freedom, democracy, etc… The youngest generations may take stock of the fantastic legacy left by their forefathers.[10]
In France, a project run by the National Foundation of Gerontology tries to make school-children look into the attainments, which are the privilege of age. The title of the project is "Growing up is Aging, Aging is Growing up."[11]

New data from the Swedish study on "Seventy Year-Old people in Gothenburg" address the issue of "Life Events and Quality of Life in Old Age."[12] Among the negative life events, which may strongly impair the quality of life of older people, children's divorce, the loss of spouse, and personal illness ranked as the most severe. Reports of positive life events included the birth of a grandchild, a spouse's recovery from illness, and finding a new partner. It is clear from this study that family links are major determinants of well-being.

Quality of life and attitudes towards aging

In the *Fountain of Age*, Betty Friedan describes very well how our own fear of aging leads to a catastrophic image of this normal process considered as a "problem" instead of an accomplishment. She also emphasizes that we gerontologists contribute to this negative image because we usually focus our studies on the decrease with age of a number of functions without pointing out that some other functions improve with experience of life.[13]

In contrast, Antonini remarkably analyzed that the creative capacities of the painter Monet were magnified and not impaired by the emergency of a visual deficit as he aged. The chronological sequence of the "Nympheas" of Monet shows that the losses of structure of forms as well as the monochromatic tendency appear concurrently with the increase of the visual deficit. These paintings constitute a striking document showing that physical decadence does not necessarily lead to a creative decline, but, on the contrary, a change of style which places Monet among precursors of non-figurative art.[14] It is clear that satisfactory health status of the aging population can help promote an image of productive aging. Productive aging has proven to be possible even among the handicapped and frail aged. Indeed, they invent fantastic compensatory strategies, they judiciously use their remaining capacities, they circumvent problematic situations, and they transform handicap into gain. This is how older people build up their own quality of life.

What is quality of life and do we know how to measure it?

That should have been the first question to address. Slow but important progress in assessment of quality of life is being made.[15] Measurement tools are being developed, mainly in the health related domain,[16] and a number of these tools are specifically focused on the geriatric population.[17] We are able to analyze and measure some of the physical, psychological and social determinants of quality of life. We still do not know what quality of life is because its origin is buried in the essence and mystery of human nature.

Quality of Life in an Aging United Kingdom

Baroness Sally Greengross,ILC-UK

In the United Kingdom today, not all older persons look forward to the second half of life. They hope and expect to be able to participate, to have a feeling of self-worth, to continue to make a contribution toward their own lives and the life of the community within which they live, to exercise choice, and to be recognized as fully participating members of society. But this is not always possible.

The indices which are used to measure quality of life will be different for the substantial majority of older people who are interested in opportunities to lead a full life and the increasing minorities who need some support and for whom much of the quality of life will be determined by the quality of the services they receive. Their social environment is another key determinant.

QUALYs (quality adjusted life years) represent one laudable attempt to define acceptable criteria for measuring the benefits of different interventions and enabling intelligent systems of rationing expensive healthcare resources to be made. Although the system of QUALYs is now more sophisticated, with better allowances for discounting, they still tend disproportionately to favor younger people at the expense of older people in need of treatment.

There are many factors that impinge upon the realization of quality of life for individual older people.These include maintenance of health, income, employment, access to provision of care, standards of care, adequate housing, security and warmth, a clean environment, personal desires and aspirations, and relationships with family and friends.

In broader terms, the major determinant, as throughout the world, is the dramatic shift in the age profile. In the United Kingdom, in 1994, the population was 58,395,000. Of this figure, 18.2 percent (10,630,000 people) were over the age of retirement. Almost two-thirds of people age 75 and over were women, and 8,000 people were age 100 or over. By 2031, it is estimated that there will be 34,000 centenarians.

Good health, as defined by the World Health Organization, is a precondition of quality of life in older age. Health is not just about the absence of illness. It is about how we feel and the quality of our lives. Older people must continue to have access to adequate health care provision, to education, training and employment, with increased prospects for integrated housing, and the removal of all barriers associated with aging. In the United Kingdom there are numerous examples of age discriminatory practice, for

example in the areas of coronary care and cancer screening. Older people are more than twice as likely as those under age 65 to die of heart disease, and more than five times as likely to have a heart attack. Yet 20 percent of coronary care units have age-related admissions policies and 40 percent restrict the giving of clot-busting drugs to older people. Forty percent of post-heart attack rehabilitation programs impose age limits—with no scientific reason. Although cancer is most likely to occur in later life, cancer in older people is often under-treated; up to a thousand men and women in the UK die unnecessarily of cancer each year as a result of questionable assumptions about their capacity to cope with surgery, radiotherapy or chemotherapy, based simply on their chronological age. In fact, there is a lack of information about older people's response to cancer treatment because they are often excluded from research trials. Sixty-three percent of deaths from breast cancer occur in women age 65 or over, and breast screening is more effective in detecting cancer in this group. Yet they are excluded from automatic invitations to screening, which are a normal part of the UK's National Health Service.

There is much to be done in this field because, in the UK as throughout Europe, there is no legal basis that can be invoked to counter age discrimination. Age Concern England is currently leading a campaign on breast-screening for women of age 60 and over and was recently involved in an initiative with the Royal College of Nursing, United Kingdom on age discrimination in health care, "Health Care Rights for Older People, The Ageism Issue."

Further training is needed for health service staff about the aging process itself, to counter myths about aging and treatment, and increased resources must be made available to allow older patients to be offered the full choice of treatments.

In the field of employment, in the United Kingdom, 50 percent of males age 50 and over are no longer in full-time paid work. Fifty-one percent of pensioner households depend on state pensions and benefits for at least 75 percent of their income, with (in United Kingdom terms) the most severe deprivation being experienced by pensioners living alone. In terms of housing and care, a minority of older people need long term domiciliary or residential care, with the majority being able to maintain themselves, very often with minimal or no extra support, in their own homes.

A lack of contact between generations may lead to each generation seeing itself as separate from, rather than part of, a larger community. Older people often feel left out, with their experience undervalued. Age Concern is responding to this by reaching out to older people (who may think they have no value) and showing them that their opinions and ideas are really relevant to all our lives through the development of a number of national initiatives. Trans Age Action—The UK Foster Grandparent Programme recruits and trains older volunteers to work with vulnerable children and their families. At the same time, we expect shortly to appoint staff to work closely on aspects of the National Curriculum enabling younger and older people to share the joy of learning together and, more importantly, to enable older people to work as mentors with young people and use technology and design to enhance the quality of life for older people now and in the future. A further, more developed program is Ageing Well UK, a health promotion program that uses older trained volunteers as Senior Health Mentors to deliver health messages to their peers.

The passage from this millennium to the next provides an opportunity to stand back from every-day events and to rethink our future.

Age Concern, in its role as the National Council on Ageing, is initiating and facilitating a process whereby people of all ages and from all walks of life are currently being invited to take part in the Millennium Debate of the Age. The challenge is to stimulate people to debate the implications of an aging society, to produce a consensus about policy priorities, and to gain commitment from decision-makers to take forward the final proposals.

In the future, chronological age should be irrelevant to quality of life. It needs to be based on publicly acknowledged and accepted criteria and upon what in our heart of hearts we feel to be right.

QUALITY OF LIFE—BACKGROUND DATA OLDER PEOPLE IN THE UNITED KINGDOM, DEMOGRAPHIC TRENDS

In 1993:

- A man of 60 could be expected to live for another 17.8 years, and a woman of the same age for 21.9 years.[18]

In 1994:

- The population of the United Kingdom was 58,395,000.
- Of this figure, 18.20% (10,630,000 people) were over pensionable age.[19]
- Almost two-thirds of people age 75 and over were women.[20]
- 8,000 people were age 100 and over. In 2031, it is estimated that 34,000 will be in this age group.[21]
- Either by choice, or because they cannot find employment, men are retiring earlier. The employment rate for older women, however, has been rising, due partly to an increase in the number of part-time jobs, and the fact that women have fewer children, have children later, and are more likely to return to work after having children. 51% of men age 60-64, and 69.3% of women age 45-59 were working. The projections for 2006 are 49.1% of men (age 60-64) and 72.6% of women (age 45-59).[22]
- In Great Britain (England, Scotland and Wales only) people from ethnic minority groups made up just less than 6% of the population.[23]
- The number of people of pensionable age is projected to grow fairly slowly for the remainder of the century, rising by 2% over the next ten years.[24]

Income

In 1993:

- 51% of pensioner households depended on state pensions and benefits for at least 75% of their income.[25]

In 1996-7:

- The basic weekly pension was £61.15 for a single pensioner, and £97.75 for a couple.[26]
- Pensioners living alone who were mainly dependent on state pensions experienced the most severe deprivation. 52.8% of their expenditures went for housing, fuels and food.[27]

Living Alone

In Great Britain, in 1994:

- In the 65-74 age group, 18% of men and 39% of women lived alone, and 33% of men and 59% of women age 75 and over lived alone.[28]

Caregivers

- In Great Britain in 1990, among caregivers who devoted at least 20 hours a week to caring, 44% were age 46-64, and 28% were over age 65.[29]

Health and Community Services

- In 1991, a survey sample of 10 European countries showed that in England and Wales winter deaths were 19% above average. The rates for Germany were 4% and Sweden and Norway 7% above average.[30]

- In Great Britain in 1994, 83% of NHS GP consultations took place in the surgery. Consultations at home were most likely on behalf of children under age 5 and among older people. Nearly one-third of those age 75 and over consulted their GP at home.[31]
- It is estimated that around 40% of total hospital and community health service expenditure is on people age 65 or over.[32]
- It is estimated that 5% of the population age 65 and over and 20% of the population age 80 and over suffer from dementia.[33]
- In 1993, only 24% of angina patients that were given x-ray examinations of the coronary arteries were age over 65 and 4% over 75. For angioplasty, 17% were age over 65 and only 3% were over 75. For by-pass surgery, 30% were older than 65 and 3% were 75 and over.[34]
- Although most people with cancer are older, cancer in older people is often under-treated. It is widely and erroneously believed that cancer is less aggressive in older people, and that treatment is less effective. In fact there is a lack of up-to-date information about older people's response to cancer treatments, as they are very often excluded from research trials—in itself evidence of ageism.[35]

Housing

- In Great Britain in 1991, single older people over 60 in the private rental sector occupied 46% of the worst housing.[36]
- In England in 1995, 285,894 sheltered housing units for older people were rented from local authorities; 163,510 from housing associations; and 89,642 were based in the private sector.[37]
- In 1995, in England, the chance of living in a long-stay hospital or care home by age was: 0.05% (under 65); 1% (65-74); 5.5% (75-84) and 25.2% (85+).[38]

Examining Quality of Life: The Viewpoints of a Japanese Businessman

Shigeo Morioka, ILC-Japan

INTRODUCTION

The Perspective of this Report

I would like to speak to you as one of the business people who helped rebuild the Japanese economy after the war, which ultimately achieved a high level of growth. I will give you my personal view on the improved quality of life of the Japanese public up to the present time, from a social viewpoint, and how we should view quality of life in the future.

The Achievement of Japanese Society Up to the Present

Remarkable results were achieved during Japan's economic restoration in the 1960s under the leadership of the central government, especially in heavy industry, the chemical industry, the home electric appliance industry, and the construction industry. In this period the government, corporations and the general public joined forces to bring about social and economic progress. Efficiency, progress and development were the central values of this period. Devoting themselves to the development of the company meant fulfillment for workers and, at the same time, improved family life, which, in turn, led to the development of the country and improvement of the quality of life of all citizens. (See Table 2.)

The center of our life at that time was the company we worked for, and consistency in the value system was seen throughout the country; in every company, among our families and at the individual level. The key words that characterized that period were: industrialization, modernization, urbanization and the formation of nuclear families. Efforts were made to innovate technology and increase the sophistication of industries. The demand for younger workers who adapted more easily to new technologies increased, and along with it, the middle-age and older-age labor force became less appreciated. On the other hand, the promotion and wage increase system, which is based on the seniority system, was further reinforced.

In the 1960s, companies were ahead of consumers, creating new perceived needs and manufacturing better products. It was a challenge for companies to build the economic foundation in order to improve the general quality of life.

In the late 1970s quality of life began to be discussed as an important issue in Japan. We had reached a point where the basic material needs of daily living, such as clothing, food and shelter, had been met. The public interest began to shift to higher quality of life, spiritual fulfillment, and intellectual achievement. It became evident that economic affluence does not necessarily bring spiritual affluence.

A materialistic lifestyle no longer was the desired quality of life. Along with this change in attitude, an attempt was made to create indicators that could measure quality of life.

Since the 1980s, when we entered the period of economic maturity, the public has had more interest in not only monetary consumption, but also increased leisure time. The Japanese have increased their awareness of the importance of spiritual wealth and of time itself. People have begun to seek more spiritual richness and more free time to spend as a part of their pursuit of quality of life.

Unlike the period of high economic growth, when the national government and corporations focused on economic growth without diverting attention to any other issue, diverse approaches to life, rather than a singular approach, have appeared. A variety of living arrangements have become acceptable. The key terms that will characterize the future aging society are decentralization, deregulation, a borderless society, individualization, the tendency to be unmarried, and self-initiative. The system of promotion and wage increase based on seniority will collapse in time and be replaced by the appraisal of workers' abilities based on their "functional age," rather than their chronological age.

Basic Approaches to Identify Quality of Life Issues and the Requirements to Realize Improved Quality of Life.

The aging of the population in Japan will progress at an even faster rate in the future, and we will have a "super-aged" society, with one out of every four people age 65 or older by around 2025, a rate of aging which is unprecedented in human history (see Figure 1). In this context, I believe that quality of life in the aging society is basically attained by guaranteeing, (a) spiritual satisfaction and, (b) stability of livelihood (economic, health and housing). When these two needs are guaranteed, individual citizens will be able to achieve a way of life that allows them to fully express their own independence and initiative, and voluntarily take part in social activities.

A variety of fundamental needs must be met in order to maintain and improve quality of life in these two basic areas. I believe it is appropriate to point out six fundamental types of requirements in this regard, namely economic, housing, occupational, spiritual, and health and social participation. (see Table 3).

Quality of Life of Older People in Japan

The methods needed to improve the quality of life of older people will become an important issue in the future. Long-term care insurance has been created in Japan through legislation, with compliance required by April,2000. This system will expand publicly-funded basic benefit coverage to include long-term care, just as is the case with medical care and pensions. This system is expected to decrease the substantial number of bedridden older people in our country. With this new system, we anticipate that a comprehensive welfare policy, combining medical care, pension and long-term care programs will be implemented in the 21st century, and that qualified older people will have the most important components of their quality of life guaranteed.

The economic requirements for most older Japanese will be met, but their spiritual quality of life may not be addressed. I believe the ultimate problem remains coming to terms with, and achieving a final acceptance of, the inevitability of death. Perhaps the wish of older people is to bring their life to a successful conclusion while keeping themselves free from illness and suffering and, at the same time, to maintain their contact with society. The movement to achieve death with dignity has become active in our country as well. I reject a lifestyle that forces me to merely continue living while sacrificing my dignity as a human being.

TABLE 2

Highly Industrialized Society and Super-Aged Society

	Highly Industrialized Society	Super-Aged Society
Peak Time in Japan	1960s	Around 2025 (persons aged 65+ = 30%)
Key Words	Industrialization, modernization, urbanization and the formation of nuclear families	Decentralization, deregulation, borderless society, individualization and the tendency to be unmarried
Basic Social Unit	Household	Individual
Government	Big government	Small government
Major Values	Efficiency, progress and development	Independence, symbiosis, participation and equality
Major Industries	Heavy industry, chemical industry and construction industry	Medical care, education, welfare and information science
Center of Life	Company	Local community
Production and Consumption	Production => Consumption=> Disposal	Production => Consumption=> Recycling
Consumption	Monetary consumption	Time consumption
Life Course	Uniform and mono-course	Time consumption
Life Course	Uniform and mono-course	Diverse and multiple courses
Family	Nuclear family	Diverse family structure
Men and Women	Society with division of labor by sex	Men and women become joint labor participants in society
Age	Society divided by age groups (divided by chronological age)	“Ageless” society (divided by functional age)
Culture	Youth oriented culture	Culture free from age

Source: “Lifestyle in Future Japan – Super Aged Society.” Administrative Planning, 19(3),1996.

TABLE 3

Quality of Life Requirements in an Aging Society And the Means to Satisfy Those Requirements

		Requirements attainable primarily through individual effort	Requirements attainable primarily through companies	Requirements attainable primarily by the public sector
1) Economic Aspect	Securing sufficient income to provide clothing and food	Health,income savings and education on special skills, etc.	Working conditions and the wage structure	Securing sufficient income to provide clothing and food
	Enjoying leisure and recreational activities	Health,income and savings	Club activities and working hours (free time) [Development of the private sector service industry]	Living environment and social infrastructure (parks, cultural facilities and transportation/ information/access)
	Freedom from worry when one is sick	Health,income, savings and family	Insurance system	Insurance and medical services
2) Housing Aspect	Securing one's own home and private rooms	Income and Savings	Siting of companies and financing	Housing policy, land price policy, land use/ siting ad financing
	Possessing standard consumer durables	Income and savings	Wage structure [Cost reduction through private sector technological innovation,advertising activities and credit sales systems]	
3) Occupational Aspect	Engaging in stable work	Health and education on special skills,etc.	Stability of companies	Employment system
	Achieving fulfillment through work	Discovery of specialties	Corporate personnel policy	Setting targets
	Eliminating discriminatory treatment between older and younger workers	Education on special skills, etc.	Employment system	Working conditions
4) Spiritual Aspect	Freedom from isolation/ feeling loved	Family/community activities and hobbies		Transportation/ information access
	Devoting oneself to various hobbies	Cultural activities and stable income	Club activities [Private sector hobby-related facilities]	
	Religion			
5) Health Aspect	Staying healthy	Sports, health management and emotional stability	Insurance/medical system, club activities and working conditions	Insurance/medical system and living environment-related facilities
6) Service Aspect	Being helpful to local community/society	Education on special skills,etc.	Investing in community	Forming a sub-community
	Teaching others special skills	Education on special skills,etc.	[Private sector educational facilities]	Providing facilities
	Serving the under-privileged	Education on special skills, etc.		Appreciating service activities

* Source – "Quality of Life in an Aged Society," Japan Research Center, May 1992, p.18.

Concluding Remarks Commentary

Charlotte Muller, PhD, ILC-USA

It's an honor to be here with the distinguished representatives of the other countries, as well as our own ILC and to see more than a glimmer of world recognition of the major transformation that is being accomplished as the demographic profile changes.The task of making this happen in a "user friendly" fashion is really a challenge for decades ahead. Looking back on history, it does take time for all of these things to become familiar and comfortable. I think it is for that reason that we see many anguished and even angry debates about the position of the aged in society.

I would like to just walk with you through the notes I have taken as the speakers were presenting, plus my thoughts about some of the issues.

What I say is going to be more economics than maybe you think is justified. But a lot of things have a way of being expressed in the vocabulary of economics, because the choices that societies make are ultimately about allocation of resources, both real resources, and those of time and attention. These choices weld the quantitative and the qualitative. And, of course, as Dr. Alvarez pointed out so eloquently in her earlier remarks, there is not much quality of life if you don't have food, basic needs of life, a bed, and a decent standard of living.

Since older persons in the less developed countries are often in a position where mortality has been lowered but fertility has not really been lowered all that much, there will be pressing needs of children to be met. And if the country, at the same time, is faced with the challenge of designing a pension system or a really universal social security system, there may be the basis for a well-thought-out program of international aid in which more affluent countries might engage.

In addition, there is the general issue of economic opportunities for older people. The labor market has been structured differently from what the future may require. It is geared toward full-time employment and more or less universal retirement at what is even called in our country's governmental structure, the "normal age of retirement," with variation in benefits permitted if you take early retirement or choose to work later on. But this is not necessarily a good fit to the situation of older people, a problem that is not confined to our country. There is a shortage of appropriate part-time work that older people can do, and there are many more who would want to work if they could have a part-time schedule.

There is powerful competition with the needs of people entering the labor market to get some footing so that they can go ahead with the

progress of their careers. Therefore, there is a need for more opportunities that will not involve direct competition for those kinds of work. I am thinking of promoting home-based work, and getting technical assistance and access to credit to older people who have the initiative to try to set up a little business of their own, maybe not to bring in a full income, but to supplement what they may be getting from Social Security or savings or pension.

I am also thinking of imaginative use of the labor time of older people, to meet needs that the market is not intending to meet for the foreseeable future. Those could be unmet needs of old people or they could be unmet needs of other age groups or divisions of society. What it takes is the connecting fluid of cash from another source besides the private market. This is an enterprise that might meet two needs at once, namely, to provide employment, and at the same time to bring the standard of living up toward adequacy in some domain of social and individual life, for example, housing—the repair, the construction, the modification of housing that older people occupy.

There is a need for data that will assess the number of older persons who are well positioned in regard to this issue. I had the privilege of working on a census planning group for the UN with the gracious cooperation of Dr. Volkov and Dr. Gnanasekaran, who are in our audience here today. The census questions that are asked do not necessarily fit what is going to be the work experience of older people. For example, asking whether you were employed regularly in a certain reference period may not pick up what's happening to people who work intermittently through the year, or who pull together several different sources of income, or who do not in some way fit the standard definition.

We also have an imaginative opportunity to develop the volunteer arena in ways that have not perhaps been fully thought through in the past. I don't see it necessarily as a case for absolute categories of volunteer versus paid work. I think it is possible that older or other volunteers get some reward of value besides a plaque or a certificate at the end of the year—credits toward a service that they may need in the future, for example, or a service that is being provided by the institution that they are helping out. A little imagination and creativity could find good fertile fields here and also accomplish social integration in a more painless way than perhaps was possible.

Now, if older people are contributors to society through their consumption spending, that is great, but are they being treated right? Is the customer getting the attention that the customer could use? I am thinking of an older friend of mine, a retired economics professor with impaired vision, who has trouble reading the tiny print on labels in the supermarket. Why does that have to be? There are people with arthritis who can't very easily reach the bottom shelf in stores. Why can't there be some lifting device or another form of display that would make it a little more of an independent process to be on your own in a store? There is an untold list of things that can be done of that nature, and some of it would improve the use of leisure time as well. The first VCRs were so difficult to manage that even getting the VCR Plus didn't help. And it was only when the first one broke down, and a new one had to be purchased that the consumer got to use a screen menu to record programs. This is a prototype for what ought to be done to open the doors of computers to older people, by thinking through how to get people up and running a lot faster than is now possible. That would improve employability as well as creating kinds of power over information sources, and serve recreational purposes as well.

The public sector itself has a lot to contribute, more than simply income maintenance and health services, precious and central as those are. For example, making sure that roads and streets are in good shape and are well lit, so that older people who like to walk don't become a health statistic. If you have a library, of course, making a bigger and better library is fine. But how about a gym as an annex to the library? Or a library as annex to a gym to try to get the mental, spiritual and physical all in one place? A lot can be imagined there.

Now, coming to the question of income—and as an economist I unapologetically come back to that because it is essential—you can't get a lot of the things you like in a market economy without it. We don't have good consensus of the kinds of statistics that best represent adequacy of income and fairness of its distribution. This is an area for lively discussion, as it should be, because one serves different purposes and answers to different constituencies by upholding the value of particular kinds of comparison. For example, should one measure the wage replacement rate of current pensions? Should one measure whether people are in poverty all the time or whether they are at risk of plunging into poverty if they have a large catastrophic medical expense? We know much less than we ought to know about the economics of the household, the transfers and sharing and lack of sharing that may go on in multi-generational households and in families, which may be closely connected with the well-being and the daily maintenance of the older person or couple.

Quality of life, especially for older people, is a territory claimed by several professions. Economists refer to well-being, which can't exist without a given consumption level. Behavioral scientists refer to self-esteem, morale and satisfaction with aspects of one's life. Medical clinicians and ethicists use quality-of-life terms in discussing the wisdom of aggressive treatments and life support. In health care regulation, quality of life for older people has been used to describe human relations aspects of institutional style as distinct from sanitation, safety, and adherence to protocol. For many years, the concept of disability in country statistics was confined to people up to the age of 60 or 65. But now the UN Statistical Division has advocated expansion of national statistics to embrace functional activity levels and participation among the older population within the concept of disability.

These usages suggest that one super-index of quality of life for older people is not a realistic prospect,but they are encouraging because they show that many systems have a vision of improving existence in old age.There is a common respect for the importance of the minimum level of economic resources and access to health services.The value of dignity is widely shared and is related to retaining choices. Although the level of achievable happiness and the potential scope of activities will vary from person to person, policy makers should try to identify critical circumstances that can result in a cascade of deterioration in functioning, relationships and morale. Building appropriate safeguards against these happenings would be the next step in public policy.

COMMENTARY AND QUESTIONS FROM THE AUDIENCE

Comment: I don't know if this is a coincidence or if you have unusual powers. It just happens that today, in Sweden, the Democratic Socialist Parties are meeting, and their theme is Quality of Life: Resource and Allocation. It is an opportune time because, for the first time since the 2nd World War, in 13 out of 15 European Union countries, the governments are either controlled by Socialist Parties, or the Socialists participate in the government. Germany, however, has left us without a center-to-left government.

One of the issues that was also raised is that in Europe over the last 10 years, under Maastricht, the taxes paid by the top 10 percent of the population have been reduced by over 20 percent. The taxes paid by corporations have been reduced by over 25 percent in the same period. Where are the pensions? In the real time dollars they have decreased in value. Health care expenditures have also gone down in real time dollars. Maastricht calls for even more radical reductions in spending in both of those fields.

Robert N. Butler: For those who may not be familiar with it, the Treaty of Maastricht indicated that to move to the Euro, which is the common currency in Europe, governments would have to have less than 3 percent of their GNP in deficit.

Comment: I would just like to follow up on that last comment. A number of panel members have talked about the importance of economic security. And as we see from the data that has just been mentioned, and as the proportion of the population 65 and over becomes larger relative to the economically active population, we are going to see governments increasingly cut back the amount of public funds that go to support people economically in their old age. And what this means is that there is going to be, it seems to me anyway, increasing need for younger and middle-aged people to provide more and more for their economic security in retirement. Now the data in this country shows that they do this very badly. If you look at just one measure of the quality of life, such as if people can maintain consumption standards when they retire, they can't. Consumption levels drop precipitously, in this country—a developed country—on retirement. So it seems to me that there is a real need for public, non-profit and private organizations to encourage younger and middle-aged people to begin thinking very seriously about their retirement. And yet we don't see very much of this. I am very interested in whether or not there are increasing efforts at this level in the different countries.

Françoise Forette: I quite agree with you. But we have recently conducted a study of people between age 45 and 50—the future old people. They are so overwhelmed by the economic difficulties now that they do not want to think about their future as older people. So the real problem, and I think that is one of the objectives of the Longevity Centers, is to make visible the fact that we are going to grow older and older, and that it is our responsibility to know what we want to do when we are older. So I quite agree with you.

Sally Greengross: The situation is the United Kingdom is somewhat special because of the comprehensive welfare state.The welfare state was established so health care through the National Health Service would be free and would remain free for everybody at point of delivery, according to need. But social care through the social services and social security payments were never envisioned as being available free. People have to pay towards that according to their means, but this was not really made clear. Many problems have emerged because people's expectations of care "from cradle to the grave" have not been met. Public awareness of this has been very, very sudden and very recent. A lot of older people feel very angry and let down, quite justifiably, in some cases, because what health providers can do, if they are short of money in their own budget, is to switch the older person out of the health budget and into a social care budget, i.e. from hospital to residential or community care facility and then the individual will have to pay if able to do so. The recognition that they are going to have to pay towards that type of care has been a rude awakening for a lot of people. And there is now a convergence of views, I think across the political spectrum, which is very similar to that in most

other European countries, that the social security budget can only meet the needs in the future if there is a basic state guarantee of some sort, or underpinning to those with a means of their own. But the people will have to supplement state benefits with their own savings whenever possible. And this has actually now become a realization to everyone and the anger regarding the future is lessening, although today's older people are unable and certainly unwilling to make this change. The new government will make, I think, very little difference in the UK because of the spending criteria set by Maastricht, which is what the gentleman there was talking about. There will be some redistribution, but it will be limited by European criteria according to which every country is working.

Shigeo Morioka: In Japan, like in Britain, as Baroness Greengross mentioned, the government controls the provision of welfare in terms of medical services, patient, and custodial care. Therefore, basic welfare is guaranteed. But as I said before, after the year 2025, one out of four people will be 65 plus. So the question is whether or not, when that situation arrives, we can maintain the level of services we enjoy right now. So therefore, the Japanese government toward the 21st century, or toward the year 2025, has to prepare itself with proper policies so that it can maintain the current level of welfare. But in the future, more than ever, we have to promote the concept of self responsibility to the Japanese people.

Julia T. Alvarez: Because we are at the UN, and picking up on something that Dr. Muller said above statistics, I think that we do not have a clear picture of how older people fare in different countries, both developed and developing. In 1990 the United Nations came up with the Human Development Report, which measured the wealth of a country and the level of human development—how the people did. Two of the indexes were illiteracy and life expectancy. Now it was amazing to find that, for example, Costa Rica, which is a small, poor country, is doing just as well as many of the developed countries. This is because of their policies.They do not have an army. They spend all of their money on human beings. So, therefore, they were doing better. Now when the Beijing Conference—the 4th World Conference for Women—was celebrated in 1995, they presented a gender development index. I went to see someone who produced this report, and I offered encouragement that perhaps in 1999, we could formulate an age development index, which would give us some idea of how older people were doing in different countries. I think that would be a wonderful contribution for the year.

Alexandre Sidorenko: If you are to try to identify the resources that might be available internationally to support developing countries in addressing the quality of life of older persons in their countries, as well as the issues which relate to the development of society for all ages, then, unfortunately, I am not in a position to give you any sort of encouraging developments, either within the United Nations or outside of it. And to give you just a very simple example, the United Nations Trust Fund for Aging was established shortly before The World Assembly on Aging to support the Assembly itself and was later transformed into a small fund for supporting projects on aging, primarily in developing countries. Initially, immediately after they developed the Assembly on Aging, the fund held more than $2 million. The trust fund had shrunk to less than $60,000 in 1997. I believe this reflects the state of the Association on International Aging, particularly in terms of technical cooperation.

Comment: There is an initiative in the Pan-American Health Organization (PAHO) to partially sponsor, with contributions from the respective countries, a seven-country study of aging in

Latin America and the Caribbean. They are now bringing together demographers, economists, survey methodologists and a few other folks to start planning the design of a survey that would have comparable measures for primarily the major urban centers in seven countries in Latin America and the Caribbean. This is the first time that I am aware that there has been any focus at all on aging issue, in the Pan-American Health Organization. So I think this is a major move forward.

Question: I have been trying to understand two trends in relation to population aging around the world, particularly as it relates to the United States. One has to do with what my colleague was mentioning, the polarization of incoming wealth. The other has to do with the role of the nation state in the coming millennium. In my view, the older population in the U.S. has been helped mainly by what has been done by government, especially the national government. If, as is written in a recent issue of The Economist, there is such a thing as a disappearing tax payer, because there are many ways that companies can get benefits by relocating jobs to different countries and taking advantage of different tax structures, if there is such a globalization of the economy that it is hard for the nation states which have developed social security and other resources for the old population to maintain them, in what way can we harness this globalization so that older people, in the future, are not left behind? If someone could comment and perhaps assuage some of my fears about the future, I would be grateful.

Shigeo Morioka: Earlier there was a question about the discrepancy between developing and developed countries, and if there is any solution to this discrepancy. I feel that the solution is education and training for developing countries, and the technical transfer that is suitable for the particular developing countries. I think it might take a long time. However, I think this is an important problem we have to address.

Comment: I am very impressed by the issues that were raised about the quality of life of older people. However, I don't recall the issue of peace and the effect of the economic pressure in countries at war and in civil strife on the welfare of older persons being addressed. Older people must be participants in the legislative process to see that we have peace in our countries and in the world. When someone wants to make way-out, fantastic missiles, the first budget cuts are in services for older people and children. So I think that the issue of peace is a very important aspect of the quality of life of we older people, as well as the environment in which we live and the environment that we are going to be leaving to the younger generation.

Robert N. Butler: I think that is a very interesting point. Maybe we need the whole world to become like Costa Rica.

Question: Throughout the industrialized world there is a dramatic drop in fertility and birth rates. According to American demographics projecting out into the future, some countries may, in fact, disappear. One report said that in 400 years there won't be any more Italians.

[Robert N. Butler:The Italians will make a last stand, I can assure you] As things are going, death rates all over the industrialized world are exceeding birth rates. But in the interim, of course, this doesn't take into consideration break-throughs in the treatment of disease and the possible breaking of the genetic aging code. But whichever way you cut it, there are smaller generations coming, perhaps very small generations, as has been pointed out, to support an ever expanding older population. How are the various countries dealing with this issue of declining fertility and birth rates?

Françoise Forette: I remember one day, I made many presentations before an audience of businessmen, and I showed data that indicated there is a decline in fertility in all countries, and one of the gentlemen stood up and said, "Well, don't you think that we men could make our wives come back home, and we will make our babies?" I am not sure this is a solution. But in Sweden they have had a very interesting policy, and the birth rate increased, but only for two or three years, and now it has stopped. I think there is no solution to that. In fact, maybe we simply have enough people in this world.

Robert N. Butler: Richard Leone, who is an economist and president of The 20th Century Fund, has pointed out that it costs approximately $300,000 to raise a child. I should say rear a child. In fact, the total dependency ratio has been declining since the year 1900. In other words, the declining birth rate coupled with the increasing number of older persons divided by working generations, has actually declined. Furthermore, the fact that you have fewer working people does not mean that there is less productivity. As a matter of fact, all you need to do is look at the agriculture industry, and observe that in this country, which was originally agrarian, only about 2 percent of our population is now needed for agricultural production. So I think it is an unnecessary fear, and that it is very healthy that we have success in family planning. In fact, we need more of it in Africa and in Latin America.

Sally Greengross: Absolutely, but I would like to add one comment. In many European countries, such as France and Britain, some of the fears have racist undertones. That is very unfortunate because you can think about this being a very positive trend. There is a shakeup in the age profile and the balance of the population. But it will shake itself down and then we have a different population with a different balance between old and young. But that does not mean that it is not as good or even better than the current one.

Question: Several of you spoke of the importance of family relationships, intergenerational relationships, and intimate relationships to the quality of life, for everyone, not just older people. Yet, we are seeing the fragmentation of the welfare state and strong efforts to make it disappear in a number of countries. It is reflected, to some extent, in the breakdown of the intergenerational contract. To the extent that it succeeds, it will intensify this atomization of society. To what extent are these two states compatible with one another?

Sally Greengross: I don't think that in Europe, as yet, and in my country in particular, there is a disappearance of the personal relationships between the generations. It has changed a lot, but I don't think that looking back to some golden age when people were closer and related better to one another across the generations is as realistic as it sounds. It depended a bit upon the levels of poverty that people experienced, whether they could, in fact, look after the other generations adequately. But it is terribly important, I think, for all of our countries to actively work to introduce measures through which people confirm that commitment across the generations. And hopefully something can be done to reaffirm this in time for 1999. I think that is what we all hope. It is such a wonderful opportunity and the theme of the year is so much geared towards this. If in various ways we can get people of the different generations to understand each other a bit more, then I think this reaffirmation may counteract the measures, which tend, though not by design, to oust older people from the benefits of society. Very often the group that reinforces that tendency is old people themselves, who imagine that they don't merit adequate pay-offs from whatever sort of welfare state people enjoy. They have this sense that the goodies should go to the young first.

And what we have to do is to make sure that declarations about social justice are intergenerational. That applies in employment, where a mixed age workforce is a better way of talking about things than an older workforce. And a mixed age social benefit according to individual need is a better way of looking at things than divisively between old and young.

Comment: A major element of well being for old or young, in fact, is the absence of abuse and neglect. There was not a single word in all these wonderful presentations about one service, if not obligation, that the public, the state, the nation or other services should assume in preventing elder abuse, or at least in training to educate, people who deal with older people to avoid this very sad phenomenon that prevails much more than we all would like to admit. I publish books about it, I see statistics about it and so, unfortunately, I am quite aware.This does not concern only nursing homes, residential homes, and health institutions. It concerns everyone who is in touch, from social workers to health workers, to families.

Robert N. Butler: I think it is very important that you have raised this. It is also important to know that the problem of elder abuse cuts across all social classes. It is not simply a function of poverty.

CLOSING COMMENTS

Alexandre Sidorenko: It appeared to me that the main issue during our short discussion has been income security in old age and the role of intergenerational transfers. This has been the case in the international discourse on international aging for at least the last 10 years. It is quite obviously the most important issue in the arena of international aging. I would like to draw your attention to the four concepts which form the recommended framework for discussions leading up to the United Nations International Year of Older Persons in 1999: (1) the situation of older persons; (2) lifelong individual development; (3) the relationship between aging and development; and (4) multi-generational relationships. I hope that this framework, as well as the theme of the year, which is "towards a society for all ages," will encourage international debate on this important issue. I believe we won't be able to find a solution, even if our meeting is extended to the end of the day. But the solution definitely should include what has already appeared to be a tendency, more self-reliance accompanied by sound intervention on the part of public policy available to support older persons. Thank you.

Françoise Forette: I think that inventing a new quality of life for all generations living together is really the most fantastic challenge we have to face in the next century. But I repeat that we must not consider aging, either individual aging or the aging of populations as a whole, as a disaster, or even as a problem, but as a marvelous opportunity, first to live longer—and that is important—and then to share our accomplishments and to love each other forever, with or without a new partner.

Sally Greengross: I was very pleased that the issue of abuse was brought up. Having been involved in starting an organization on abuse in my country, I would like to pay tribute to this great country because this is where elder abuse was first recognized and action was first taken to combat it and prevent it where possible. And we have all had to explain to our governments that it does exist in all socioeconomic groups, as Dr. Butler was suggesting. But, in a way, the question of quality of life is about a different level of abuse. If quality of life isn't there for older people, but people of other age groups are enjoying a decent, acceptable quality of life that is a form of abuse. What we are talking about is social justice, a justice across society and across all age groups.The portents are good, however. Older people, not just in this

country, but also across the world, are beginning to make their voices heard. In my own country, the previous government made a big mistake in introducing a tax that was going to hit older people particularly hard. They lost the European elections, they lost the local elections and they have been significantly, or virtually eliminated in the national elections. Twenty-five percent, and in some areas 40 percent, of their voters were older people. If you like, the wind is blowing in our direction. Older people are not going to accept an inferior quality of life in the future.

Shigeo Morioka: As I previously mentioned, the number of children is decreasing and the aging population is increasing. Right now, in Japan, the birth rate is approximately 1.45. If this continues for the next 100 years, as was mentioned previously about Italy, the very existence of the Japanese population may be endangered. Right now, the focus is on various policies for older people. However, the government and the citizens of Japan must show more of an interest in this issue of increasing the birth rate. For example, we must try to provide childcare facilities so that women can marry and have children and still feel secure that they will be able to continue to work. The need for this kind of a social foundation is now being discussed in Japan. We want to try to bring the birth rate up to at least 2, because unless we do, it will be difficult for future generations to support older people. The traditional social custom in Japan was to respect older people. I believe that, in Japan, the ties between parents, children, and the family are still somewhat stronger than in other countries. But since the number of children is declining and there are more nuclear families, intergenerational ties, even in Japan, may be endangered. One thing that we can try to do is foster the importance of family ties during the course of education.

Charlotte Muller: I think that this has been a very thorough discussion today and some of the people in the audience have brought out very clearly the context of problems of older people, namely the shrinkage of the safety net and the turning away from a positive role for government and the necessity of controlling military expenditures that are such a burden on every economy that has them. And I feel that has to be underscored because older people, in a way, sink or swim with the rest of the countries that they are in. And so, I would like to sum up with two points to remember. One is this notion of universality. If a program is a good idea it might be better not to label it as a program for old people. I think this is true for health care, care for the disabled, safe streets to walk on or any other program. The second point I would like to make concerns the importance of recognizing diversity within the aging population. Not everybody is going to want an extremely active physical life, an extremely active professional life or a lot of mind improvement when they age. People have their different needs and their different styles and there should not be the artificial creation of minorities. The history of society is filled with examples of this. Suddenly, if you are not having the kind of surgery that is popular, you are the minority patient. If you don't want the lifestyle that is this year's vogue, you are the outcast from the places that count with the people that count. I think there should be great tolerance of diversity because it is part of our notion of an accepting society and a democratic society.

Julia T. Alvarez: I would like to stress two points. First of all, we must stop speaking about aging as a problem. Otherwise we are never going to convince politicians that social policies are not going to be expensive, are not going to be a drain. Older persons must be seen as contributors to society, not only as a drain. Second, when we are talking about intergenerational relationships and diversity,

I think one of the points we have to stress is interdependency. This is an interdependent world, the child must depend on the adult, and the adult must sometimes depend on younger people in different stages of life. A person may become dependent, but that doesn't mean that person is always going to be dependent. If we realize that we are interdependent, then I think we will all strive to have a more just and integrated society.

Robert N. Butler: As I indicated at the beginning, we can invent the future and not simply let it happen to us passively. Recall Thomas Hobbes' fantastic statement about the brutality and shortness of historical life. Throughout history, from Plato to our own John Adams, the concept of public happiness has been a very real one. But then came the industrial revolution with all of its riches, and also its brutality, which led to the evolution of the welfare state. And it is understandable that there is now some disappointment with loss of the program that Lord Beveridge introduced in 1944—the notion of the welfare state, from cradle to grave. We are going through a very realistic period of reorientation. Also, as Mr. Morioka pointed out, it is understandable that there are concerns about the birth rate but I think the solution to these concerns is family planning that does not lead to the disappearance of children, but to the achievement of the appropriate replacement ratio, which is an estimated 2.1 children.

So let me leave you with a charge. And a charge that I think each and everyone of us should think about, and certainly the United Nations and the NGOs, the non-governmental organizations. The agenda could be very long, but these are at least three points. One, we really do need a philosophy about quality of life throughout the entire life course, not just in terms of older people, not just in terms of middle-aged people, but all people, including children. Second, we really do have to focus on multi-generational relationships—relationships that have a common core and serve all. And finally, we must strive for the development of a reformed welfare state that doesn't lose compassion.

I would like to end by thanking all of our participants for what I thought was a very rich and thoughtful set of comments.

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