HEALTH CARE FOR OLD AGE: RIGHTS, DUTIES AND EXPECTATIONS

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1.INTRODUCTION

In April 1776, the philosopher David Hume, then aged sixty-five, wrote a brief essay called "My Own Life." Hume noted that a year-long 'disorder in my bowels" seemed to him to be both incurable and mortal. Nevertheless, to characterize him as suffering from it would be incorrect. He wrote:

> [I] have, notwithstanding the great decline of my person, never suffered a moment's abatement of my spirits; insomuch, that were I to name a period of my life, which I should most choose to pass over again, I might be tempted to point to this later period. (Hume 1776)

Despite enduring the difficulties of deterioration associated with old age, Hume appears to have remained philosophical – in the popular sense of this term[1] – to the end of his life.

In this essay we compare Hume's assessment of the late period of life to the prevailing valuation of old age in our contemporary culture, and to current expectations for achieving well-being as an old person today. Our critique of what we (Rorty & Silvers 2012; Silvers 1999, 2013, 2015) and other scholars of aging (Cumming & Henry 1961, Havinghurst 1961, von Faber et. al. 2001, Phelan & Larson 2002, Katz & Marshall 2003) take to be the prevailing current cultural conceptualization of oldness is directed at a view that affects the more comfortably situated segments of the twenty-first century U.S. population, as well as populations of other nations where medical care is influenced by the U.S. youth-oriented perspective on old age. Our aim is to answer a correlative question, namely, how elders should fare in regard to medical treatment in a society where the approach to health in old age is affected by this view. Although the conceptualizations we explore are most evident in affluent Anglophone societies, our recommendations can be extrapolated to other elders as well.

2.OLD AGE: BEST OF TIMES? WORST OF TIMES?

Whereas Hume valued the distancing from everyday ambitions and concerns that advanced age brought to him, today attribution of value seems to be just the reverse. Hume believed himself to be within a few months of his death, and in fact he had less than four months to live, dying in August 1776. He testified to being tranquil, illustrating his attitude with such thoughts as these:

> though I see many symptoms of my literary reputation's breaking out at last with additional lustre, I knew that I could have but few years to enjoy it

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[1] In the popular sense, to be philosophical is, in U.S. usage, to be "rationally or sensibly calm, patient, or composed," and in U.K. usage to be "calm and stoical, especially in the face of difficulties or disappointments " See entry on Dictionary.com at http://dictionary.reference.com/browse/philosophical?s=t

and

> a man of sixty-five, by dying, cuts off only a few years of infirmities.

Except for individuals predisposed to philosophical musing[2], however, these reasons seem hardly likely to persuade people of the positive value of experiencing old age. They mostly mention what even Hume himself appears to count as negative aspects of that period of life, namely the extinguishing of pleasure in the prospects of long-term improvements in life, and the accumulation of disorders and debilitation.

Hume's most notable positive reason for giving preference to his experience of old age is his observation that

> It is difficult to be more detached from life than I am at present.

Even the prospect of greater fame, with the pleasures such an elevation in status would bring, was unenticing for Hume in his old age. Notably, Hume celebrated what people usually regret in prospect when they think about themselves becoming old. It is disengagement from the ambitions and activities of everyday life, not social recognition and participation,[3] that Hume valued.

Twenty-first century readers may not be persuaded that Hume's praise of old age was prompted purely by the estimable quality of his experience of being old. Indeed, people today may be suspicious of or cynical about Hume's assessment, dismissing it as being merely a product of adaptive valuing. Adaptive values are those shaped by realistic expectations of what individuals, given their actual situations, can achieve. Adaptive valuing does not drive conviction about what ideally ought to be, or what to opt for under ideal circumstances. Indeed, judgments that are the outcome of adaptive valuing sometimes are discounted as being flawed choices. According to this complaint, adaptive valuing is compromised for abandoning ideals and instead capitulating to considerations of practical constraint.

To illustrate, the 'happy slave' argument points out that individuals whose situations are detestable nevertheless may testify to being content, not because they genuinely feel so but because they have lost hope and dare not even dream of improvement. If, in a population, such dubious resignation becomes widespread, insufficient energy can be found for social improvement. Such an outcome for elders would be neither morally nor politically desirable.

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[2] Mary Mothersill's 1999 Presidential Address for the American Philosophical Association, titled "Old Age," is a wonderful example of the Humean view's stimulating effect on philosophers.

[3] Our philosophical accounts of Hume's and Emmanuel's adaptive valuations of quality of life in old age are not meant to track the two contending psychosocial theories of personal development in old age: the disengagement theory and the activity theory. For example, what sociologists mean by "detachment" is not what Hume means by "detached from life." Nevertheless, applied to these theories, our analysis suggests how to make the descriptive aspects of these theories compatible.

Especially toward the ends of their lives, old people can become acclimated to physiological deprivation and social disregard. They may feel hopeless because no practicable route to improve their situation is evident to them. They may be so habituated to impediments and constraints in their day-to-day living as to believe these to be natural and inescapable for individuals at their time of life, and therefore unchallengeable. Aged individuals may claim to be, and genuinely may feel, reconciled to distancing or even dissolving ambitions to engage with the challenges of daily life. Their hopes to improve quality of life may have faded with age or been overwhelmed by acute or chronic illness. Such acquiescence to terms of deprivation nevertheless is easily construed as a concession, perhaps one that should not be widespread.

From a twenty-first century point of view, Hume's adaptive abandoning of engaged activity and (implicitly) of effort to improve his situation may seem to signal a less than admirable lack of determination. Distancing one's self from life could mean abandoning laudable biological and social aims, including those that inspire pursuit of medical knowledge and social justice, pursuit of which improves elders' lives today. Hume's stance may strike twenty-first century readers as inadequate because he does not seem to want to seek a cure, or even to extend his years, detaching from life rather than attempting medical remedies or otherwise struggling to live.

A contrasting opinion about adaptive valuing, however, avoids impugning such assessments for having lowered expectations. Instead, adaptive assessment is commended for aiming at achievable goals. And not every contemporary beneficiary of scientific and social progress would find Hume's opting for detachment from living to be ill-advised. To illustrate, twenty-first century physician and philosopher Ezekiel Emmanuel announced, in a widely disseminated magazine article published in 2014, that he wishes to die at seventy-five (an age that at that time was nearly two decades in his future).

Emmanuel's motivation adapts to what he believes to be the dreadful realities of life in old age. He echoes Hume only to a limited extent, for he proposes to avoid being (very) old rather than to undergo the late-life experience Hume praised.

Hume is grateful for experiencing that time of life, notwithstanding the infirmities of age that elderly people typically must endure, while Emmanuel wants to escape that same physical and mental decline to which a long life would make him vulnerable by intentionally living less long. Whereas Hume values old age as a time of consolatory disengagement from the demands of the ordinary ambitions around which younger people's daily lives are organized, Emmanuel describes such detachment as a state of deprivation brought about by increased difficulty in effectual execution of the activities through which we relate to other people, and they to us.

Emmanuel writes that late life is a time of

> … faltering and declining, a state that may not be worse than death but is nonetheless deprived. It robs us of our creativity and ability to contribute to work, society, the world. It transforms how people experience us, relate to us, and, most important, remember us. We are no longer remembered as vibrant and engaged but as feeble, ineffectual, even pathetic."

To effect his escape from prolonged enfeeblement, Emmanuel proposes not to seek curative medical care from the time he reaches age seventy-five, so as to permit any life threatening problems to which his aged body might become prone to take their course without therapeutic rescue. Thus he agrees with Hume that old age is a time of physical and mental decline but devises a different adaptive strategy – instead of abandoning ambition, abandoning life itself.

To summarize, Hume celebrates the quality of the last segment of his life despite experiencing "the great decline of my person," whereas Emmanuel fears this same time of life. Hume expresses his praise of the period of old age in unconditional value terms, no matter that his categorical claim may be mere camouflage for an adaptive, and therefore conditionally compromised, valuation. Emmanuel, on the other hand, proclaims his aversion to a period of life when he may be deprived of his earlier physical and mental perfection, no longer can engage vibrantly in activities other people admire, and will become vulnerable to condescending treatment and even abuse owing to growing feebleness.

Something odd about the relation of Emmanuel's reasons to his resolution is at play, however. The intensity of his aversion to the prospect of decline in old age is striking. He is almost phobic about a future where he no longer can be a "prototype of a hyperactive Emmanuel," and about coming to resemble his octogenarian father in that "his walking, his talking, his humor got slower."

Describing his program for detaching from life, Emmanuel commits to refusal of life-extending measures and preventative screenings. He pledges:

> I will accept only palliative—not curative—treatments if I am suffering pain or other disability.

But merely to palliate a painful condition rather than effecting a cure actually seems pointless in principle. Surely there are many impairing conditions that are more efficiently cured, and with no greater risk, than if they are permitted to remain chronically in need of palliation, unless of course the cure is so lengthy that an elderly patient is likely to die from other causes before the cure succeeds. Pointlessly refusing to accept cures can be as misguided as futilely pursuing cures.

Regardless of the advances in restorative and regenerative medicine the twenty-first century has brought, or may in future bring, old people in our era still find themselves at a point in their life span where their horizon is very short and options for the future unpromising. Yet, given today's ardent and not infrequently proper confidence in

medicine's ability to extend and also improve people's lives, Hume's placing positive value on the last part of his life may be unpersuasive because wrongly pervaded by resignation to the defects of old age. Should Hume's judgment be welcomed by elders today as reflecting the inspiration of that cumulated wisdom we should hope for ourselves upon reaching old age? Or is Hume merely attempting to make the best of a hopeless situation? Is Hume's appreciation of detachment from the activities and ambitions of his previous life, "notwithstanding the great decline of his person" an adaptation that is preferable to Emmanuel's repudiation of such a result of aging? Or is it inferior to Emmanuel's deprecation of detachment due to his inability to see past the prospect of decline?

3.TWENTY-FIRST CENTURY DETERRENTS TO TRANQUIL DISENGAGEMENT FROM DAILY LIFE

In our own era, resignation regarding the inevitable depredations of old age – whether resulting in a Humean positive assessment of late life or an Emmanuelian gloomy forecast - clashes with the layperson's faith that in principle science knows no limit to human physiology being subject to beneficial medical intervention, and thereby to the good people may achieve through programs of preventative, palliative, curative, restorative and even enhancing medical treatment. Diminutions of capacity — for example, reductions of agility, mobility, balance, visual or auditory acuity, dexterity, memory –- are deemed pathological rather than natural. Remedies abound: diet or nutrition programs, exercise regimens, vitamins targeted for the 'silver' generation, age-reversing cosmetic creams, and of course a multiplicity of pharmaceutical and surgical interventions. Initiation of many of these age-defying and age-reversing regimens well before the late period of life is proclaimed advisable. Physicians urge preventative care, and commercial advertising suggests that aging and its associated changes may be optional, escapable or reversible simply by dialing a phone number to make an appointment or place an order for a pill or potion or mechanical device.

Mature individuals, whose bodies are inclined to develop such flaws, are expected to seek both over-the-counter and prescription medication in order to function and achieve at the level characteristic of people in the so-called prime of life. The possibilities science and technology may offer to delay the onset of breakdown owing to old age allow for plausibly depicting the typical 'mature' citizen as smiling in advertisements showing models who look (and may well be) fifty rather than eighty and seem to be engaging in energetic recreation -- boating, cycling, hiking, or golfing. And, advertising suggests, the healthy albeit aged male should be instantly ready to have sex and therefore should keep a supply of prescription medication for erectile dysfunction handy. Debate about allowing an equivalent pharmaceutical to facilitate sexual pleasure for older females is currently growing in intensity. (Jervis 2015)

The call to maintain elderly people's attachment to the activities of species-typical daily life, rather than to distance themselves from the full range of activities and concomitant ambitions of daily life, is pervasive. The assumptions are that the old want to function in conditions designed or otherwise appropriate for younger people, and furthermore that

the old should be required to function under such unsuitable conditions even if they do not desire to or cannot do so.

To facilitate old people's participation, interest in universal design, a program of product design that extends usability to the elderly, exists but is far from prevalent. (National Center for Universal Design) For example, designers and marketers can visit the Massachusetts Institute of Technology and try on the "Age Gain Now Empathy System," a full body suit that cramps the neck and shoulder, impedes reaching and bending, throws off the wearer's center of gravity, stiffens the fingers, and comes with a helmet that makes the head feel heavy and a visor that blurs vision. Attempting to function while wearing this suit is supposed to enable commercial product purveyors to comprehend the functional limitations of old age so they can create camouflaging products.(Singer 2011: 1 & 9)

Yet even old people "don't like products … that telegraph agedness," according to the article. The Director of the MIT Age Lab, Joseph Coughlin, advises that items designed for the elderly need to have broad appeal across age groups. "With any luck, if I am successful," he says, "retailers won't know they are putting things on the shelves for older adults." (Singer 2011:13)

Despite such efforts to enable elders to blend into the population unnoticed, in twenty-first century culture – at least in affluent societies – becoming old is less and less likely to be a topic of neutral discussion and more and more apt to be posed as a problem not only for individuals but for society as a whole. For example, bioethicist Emmanuel's description of the noncontributing, faltering, uncreative, and disregarded self he expects to transform into upon crossing the threshold of his seventy-fifth year is far from an even-handed account of the last period of the last span. Both intentional disrespect, and implicit disregard, of elderly individuals who do not retain youthful (or at least middle-aged) fitness is not uncommon.

In an article responding to Emmanuel's declaration, cultural commentator Suzanne Gordon observes:

> All of this ranting about facing reality isn't really about puncturing the myths of American immortalism. It's about perpetuating yet another version of the American idea of success – extending it, as you do, to the end of life. As you rail against "American immortals" what you actually delineate is not a version of the good life or death, but what aging means to "American competitives," people who cannot conceive of a life lived without races to win, mountains to climb, prizes to covet, money to be made, achievements to catalogue, and more unworkable policies to propose. (Gordon 2014)

In a culture that coaxes aged individuals to think and act young, and to pursue medical repairs to hold on to youth, the struggles of elderly people to maintain necessary activities of daily living are a deterrent to achieving the tranquility that Hume's argument for preferring old age to other periods of his life celebrates. Consider the account of life as

an old person today, as portrayed in a 2015 *New York Times* feature story. (Leland 2015) Several of the old-old (over eighty-five years) New York City dwellers whose stories are explored also seem detached from life, but not happily so.

A ninety-one year old asks "What's the good of living any more, at this point — for me? … What do I look forward to?" She was happy to make ninety but does not especially want to make one hundred. She does not want her longevity to burden her children. She does not want to suffer, saying "All of us at our age, my age, we say we want to die fast."

She is depicted as saddened and tired out by the difficulties of doing things she once took for granted. The long-term care residence where she intended to spend her remaining life closed, forcing her to move. Accessible transportation is unreliable at best, so she is isolated from family and friends. Even getting into a taxi's elevated back seat to go to a doctor's appointment is a struggle. The paratransit van she scheduled for this purpose never showed up, a common problem for elderly and disabled users of this specialized public transportation system.

For twenty-first century elders like most of the persons portrayed in this article, ill-suited housing, transportation or other difficult-to-use arrangements for executing necessary activities impose a troubling, not a tranquil, disengagement with daily life. Parenthetically, such daily struggles seem not to have roiled Hume's late life for, despite his "great decline," he reports retaining "the same ardor as ever in study, and the same gayety in company."(Hume 1776)

Granted that the quality of life for twenty-first century elders is more likely to resemble Emmanuel's disparaging characterization than Hume's constructive one. Nevertheless, it is premature to dismiss Hume's testimony about the benefit of experiencing detachment in old age for being deceptively buoyant. To decide whether elderly people have claims to curative health care that can prolong their lives – and if so whether they should pursue such care -- we need to get a fix on who is old and what it is that makes them so.

4.CHRONOLOGY AND BIOLOGY: CONDITION-BASED DEFINITIONS OF OLD AGE

When does old age start? For health care related policy purposes, membership in a population group or class commonly is delineated in terms of meeting specified conditions. Membership in the elderly population may be defined in terms of satisfying a chronological standard. Thus, for example, in the U.S. Medicare health insurance is provided, with hospital insurance premium fees (Part A) waived, for individuals who are at least sixty-five years old, are citizens or residents of at least five years duration, and have worked and paid Medicare taxes for at least ten years.

The creation of the Medicare program in 1965 under Title XVIII of the Social Security Act was motivated by employment practice of the era (which referenced such a chronological condition). At that time, health care insurance as an employment benefit ceased at retirement, mandatory retirement at sixty-five was the order of the day, and

premiums for private health insurance for elders were nearly three times those for young people. As a result, more than a third of older Americans had no health coverage. (Pearson 1965)

Even though setting a mandatory retirement age as a condition of employment now is banned for most types of jobs, the chronological age when Medicare eligibility is attained has become a condition that signifies entry into the "older Americans" population group for purposes of assuring at least minimal access to health care. But we cannot take this chronological marker as independently definitive of old age, for to invoke Medicare's chronological threshold of old age in order to justify the age used to determine Medicare eligibility is patently circular. That is, if Medicare eligibility at sixty-five has become definitive of being old, this eligibility condition cannot be itself invoked to argue that at sixty-five Americans need Medicare because this is when infirmities of old age most often start.

Furthermore, judgments of who is old are affected by people's points of view, including life expectancy in the era in which they live. During the eighteenth century life expectancy in England was less than fifty years. (Johansson 2010) So Hume's sixty-five years counted as impressive longevity in his time. But in the second decade of the twenty-first century, eighty-five years may be the new sixty-five. Or more precisely the perception – represented in the eighteenth century by the sixty-fifth birthday – that an individual is having an exceptionally long life now more usually is delayed until the vicinity of a person's eighty-fifth anniversary of birth.

Indeed, even the influence of eligibility standards for Medicare and other social insurance support for elders is much less determinative of when old age begins today. In the U.S. today, Hume at sixty-five likely would appear to be merely approaching the threshold of old age and probably not yet to have crossed into it. In a survey of US adults, respondents as a whole said old age begins at sixty-eight years. And thinking that someone is old can be affected by chronological standpoint as well as typical length of life. The subset of survey respondents over sixty-five years said old age begins at seventy-five years old, while the subset of respondents under thirty said having lived sixty years marks the start of being old. (Jones 2012)

There is similar variability globally. A UK survey shows that people over eighty years thought that old age set in at sixty-eight years, while people under twenty-five years selected fifty-four years for that same transition. (Jones 2012) In the first attempt at an international definition, the United Nations (UN) designates age sixty as the threshold of old age. (Kowal 2001) The World Health Organization (WHO) set fifty for as the transition into old age for a study of elder life in Africa because it is at this age that people (and especially women) are likely to exit their child-raising roles.(W.H.O. n.d.)

Perhaps being old should be defined instead in terms of individuals' biological condition rather than their total years of life? Biological properties associated with being old include wrinkles owing to loss of elasticity of the skin; grey or white hair or loss of hair; reduced hearing, vision, mobility, flexibility, agility, reaction time, and balance; deficits

in cognition including memory; and diminution of reproductive function. Medical diagnoses of pathological biological conditions also sometimes are invoked to delineate membership in a population class. Thus, for example, in the U.S. children can qualify to receive special educational benefits if they have been diagnosed with certain medical conditions such as dyslexia, autism, Tourette's Syndrome, or blindness. (Mahler n.d.) Can old age be similarly diagnosed by being equated with specified pathological conditions?

In regard to biological changes associated with old age, not every individual undergoes these changes at the same time in life. Graying of hair can begin as early as age ten, but more commonly starts slowly in the mid twenties and becomes prominent at least by mid-fifty. Nor is every biological decrement associated with aging equally debilitating for everyone. Some people, for example, are devastated by the appearance of silver hair while others glory in it. Similarly, some people regret reduced reproductive capability while for others the change is liberating.

Further, progress in such research fields as regenerative medicine (to replace worn-out or injured body parts with new organic ones) and bioengineered prosthetics (to manufacture non-organic replacement body parts) promise to make more and more bioengineered corporeal renewal available. Like chronological conditions which are proposed as sufficient or definitive to establish onset of old age, but which vary relative to culture or economic contexts, neutral and pathological biological conditions thus also seem too inconstant to define where in the human life span old age lies, although some may be fairly taken to signify that the individual is growing old.

Chronology – that is, having attained a specified age – or biology – that is, being in certain biological states or having certain medical diagnoses - are the prevailing candidates for condition-invoking definitions of old age. Both these approaches are sometimes relied on to determine when old age is and thereby to facilitate the recognition that one's self has become old. But both invoke standards that are extremely variable from one cultural, social, political or economic site to another, or from one biological or medical theory to another. Nor do they coordinate reliably, as individuals often satisfy one standard of being old because they meet its condition but do not exhibit the eligibility condition prescribed by another standard, as is illustrated by the aforementioned lack of coordination between chronological age and biological signs of aging.

The lack of stability of chronological definitions of old age is especially troublesome where aging subjects' options are shaped by multi-cultural social contexts, or even by multi-national political or commercial considerations. The lack of stability of biological definitions of old age is especially troubling where aging subjects' choices are influenced by an increasing multitude of medical theories. On both these views, assignment to the old, or the old-old, population categories can be unsettled – and indeed a matter of dissidence or formal contention – not the least because relative to rapidly changing cultural, social, political and economic contexts. It is important for people planning their care for their old age to have reliable understanding of when that part of their life begins, for from the standpoint of old age one's expectations about one's life may differ

importantly from the standpoint(s) of earlier periods. So it seems prudent to look elsewhere than to mere chronology or current theories of biology for an alternatively based definition.

5.DECLINING POWERS: (DYS)FUNCTIONAL-BASED DEFINITIONS OF OLD AGE

When is old age? How do people know when they now are in that time of life? There is great variation in how individuals' functional development in youth, and their functional decline in later life, affect human activity and achievement. But people generally acknowledge old age to have set in when due to advanced years they experience curtailment of physical and social functioning, often accompanied by consciousness of loss. In other words, feeling old (and especially feeling old because one is treated as old) seems to happen or at least to be greatly intensified when people age out of functionally nonproblematic or productive roles.

Initially, there may seem to be little difference between diagnostic condition based approaches to delineating old age and functional approaches to doing the same. For example, medical conditions affecting function, such as a spinal injury resulting in the inability to stand or to lift ten pounds, might be evidence of qualification for work-related disability insurance benefits or early retirement. But in such cases it is the degree of actual dysfunction, not the potential dysfunction suggested by a medical diagnosis, that is dispositive.

To illustrate, while a first step in achieving disability status that suffices for U.S. disability insurance benefits may be diagnosis of a medical condition so severe that sufferers usually cannot be employed, eligibility for benefits ultimately rests on direct evidence that the individual is in practice too dysfunctional to remain employed. In such circumstances, it is not unusual for employers who offer early access to pensions to arrange for a person's early retirement -- sometimes even against the individual's own desires, because retirement strips people of their work identities and thus introduces a risk of being labeled a burden to the population still at work.

The desirable standard for human functioning most often is expressed in normative terms about what is typical of and thus desirable for the human species, on the ground that the species would have died out if inadequate functioning were humans' typical mode. On this way of thinking, what is statistically typical of the species, or of a subgroup of the species, is presumed to be optimal or at least effective for maintaining the species or the prominence of a dominant subgroup within the species. This view relies on reports about individuals' biological condition being 'typical.' Those statistical descriptions are elided with judgments that typical persons should be designated as normal, so they also serve normatively to assert that the subjects' biological components are properly formed and their physiological processes are working well.

We can see the influence that being typical exercises by noting that, while functional decline is natural to the aging process, whether a very old and thereby functionally

compromised person is thought of as normal will be the result, at least to some extent, of the number of individuals of similar age and biological condition in the population. As in the twenty-first century sixty-five is no longer an unusual age to attain, being sixty-five also no longer commands the same degree of attention to atypically long living accorded that length of life in the context of eighteenth-century populations.[4]

Within a conceptual frame that equates normality with typicality, people with unusual biological properties or traits are readily thought of as malfunctioning, in part because a popularized (mis)understanding of evolutionary development throws suspicion on atypical biological conditions as being maladaptive or else unnatural in some respect. So what is advanced as being a detached scientifically descriptive approach to defining normal health often turns out to be a covertly partisan criterion that imposes the functional modes standard for the most populous or otherwise dominant kind of human on everyone else. Historically, such seemingly scientific definitions have been applied to condemn females and racial minorities, among others, for being biologically defective.

Old people's day to day experience during the last stage of the human life span is far from typical for the entire human population, although the process may be typical for the late period of human life. But the part of the population experiencing that period is never a majority. Inexorably declining in functional power and dexterity is typical of humans; but precisely because old age is characterized by decline as other periods of life are not, claims about burdensome greedy geezers (Silvers 2013) who have had their fair opportunities to enjoy life also have been invoked to justify abuse, neglect, exclusion and segregation of old people.

A second prominent approach to identifying old age in terms of declining function is candidly, rather than stealthily, normative. The aspirational policy that guides the mandate of the World Health Organization, a United Nations agency charged with pursuing "the attainment by all people of the highest possible level of health," illustrates important relationships among advanced age, state of health, and well-being. Depredations of biological aging on health exacerbate and accelerate decline of function, and as functional constriction impacts an individual's day to day experience of life more and more noticeably, people come to self-identify as being old.

The World Health Organization (WHO) constitution defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 1948). According to views like this, we should not think of health as merely the organism's natural biological state undisrupted by disease. Instead "health is a positive concept emphasizing social and personal resources, as well as physical capacities" (WHO 1986).

For aged individuals, having one's health cannot be having the health of younger people, so what, for them, can having one's health be? Being old ordinarily is depicted in terms of ebbing strength, eclipsed optimism, depressed initiative, and doubts about personal

[4] It is worthwhile noting that pre-twentieth-century life expectancy was strongly tied to economic class, so attaining sixty-five years was much less unusual for wealthy people than for workers.

worth. (Leland 2015) Conjoining this characterization of being old with the conceptualization that to be healthy is to function as typical members of the species makes being old, by definition, a time of losing one's hold on normal health.

Restoration of normal species functioning, or at least maintenance of current functioning, are the usual aims of medical interventions. But what if neither aim is sustainable because functional losses not only are inescapable when individuals grow old but also are definitive of the experience of being old? This is not to say that every human experiences such losses, but only to observe that by functional definition everyone who counts as being old has done so. The state of the very rare individual of greatly advanced years who has not (yet) done so usually is acknowledged by expressions like "young at heart" or "ageless," that is, as not yet experiencing oldness.

For humans (and other animals) to be elderly is to have embarked upon the time in their lives when maintaining effective bodily functioning becomes harder and harder, and eventually impossible. Of course, some individuals experience such limitation even before they reach old age. Deterioration and diseases associated mainly with the aged may manifest in forms with much earlier onset. About 5 per cent of Alzheimer's patients develop progressive symptoms before sixty-five years of age, for example, and a few do so between age thirty and age forty, although such cases are quite uncommon.

Of course, degenerative diseases such as spinal muscular atrophy (SMA) or Huntington's cause similar declines of functionality in people who have lived many fewer years than the long lives we associate with elderly people. Systematic degradation of functional power and prowess therefore is a property shared by old people and (at least some) younger disabled people. Should just younger disabled people, or disabled people whether young or old, or neither group have access to medical intervention and social support to mitigate functional deficits?

6.ARE THE OLD JUST PEOPLE WHO HAVE FAILED TO STAY YOUNG?

How can the texture of their daily living be endurable – let alone desirable – to old people if membership in the population of old persons means definitively that such individuals are in irreversible physical or mental decline with prospects that do not offer room for hope (unless a person has faith that an afterlife follows)?[5] It sometimes seems as if the popular twenty-first-century response to this challenge reduces to attempts to define the conceptual connection between old age and deteriorating powers away by insisting that humans of very advanced years can preserve or retrieve youthful health.

[5] Although our characterization of old age is focused on the experience of elders who do not believe in an afterlife, the recommendations in our conclusion are equally applicable to achieving just treatment for old people whose religious convictions convince them that they will or may have an existence after their body's death.

A captivating idea that is a signature of our contemporary culture urges old people to pursue a program of healthy aging. To age successfully is to prevent disease, maintain full function, and continue to execute the activities of admired social roles. This notion denies the conceptual overlap between being old and being disabled, suggesting that acquiring functional limitations in late life is just an empirical matter that elders who take proper care of themselves are able to overcome.

The healthy aging prescription too easily can promote expectations of not aging at all – that is, of retaining the same functionality as in earlier periods of life. To illustrate the influence of this proposal, in the U.S. marketplace it is hard to escape advertising that invites elderly men to keep medication for erectile dysfunction on hand so they are instantly ready to perform sexually whenever the opportunity presents itself. Such portrayals suggest people need not change when they grow old and their health in old age should remain as it was in earlier phases of life.

If elders remain in the same health states as younger people, they will not use healthcare with more frequency than they did in youth. On reflection, however, this promise proves deceptive. Like the components of any well-used mechanism, people's physical components wear out, buckle, or warp or otherwise deform despite being maintained meticulously and receiving the best of health care. Medical services may delay such degeneration, or replace deteriorated parts, and possibly the patient's renewed productivity may offset the price of treatment. Eventually, however, the promise of effective renewal must fade away, which revives the puzzle about the prudence of pursuing youth-like health in old age.

The Roman philosopher Cicero famously contended that there is a special character to health when one becomes old. (Cicero 44 B.C.) Upon feeling discomfort, distress, dizziness, or pain, younger people ordinarily ask how long before they feel well and what steps will hasten healing. But not the aged, for whom, according to Cicero, such feelings characteristically induce fear that their last days are about to arrive. That is to say, to be old is to be aware of – and often acutely apprehensive about – having a severely foreshortened future.

For working age adults, health is understood in terms of species-typical biological functionality in the performance of important social roles. For children, health can be related to the same standard, measured in terms of their potential to develop biological functionality rather than to current possession of it, as well as their potential to execute adults' social functions when they have matured sufficiently to do so. But biological functionality, and therefore health, declines rather than develops for the old.

Moreover, the WHO definition attributes both biological and social components to health. Initial attempts to explain the role of social factors conceived of these mainly as causes that directly depress or support individuals' biological condition. To illustrate, starvation of people does direct biological damage to their bodies' cells. As thinking about the idea of health grew more perspicacious and nuanced during the last part of the

twentieth century, however, acknowledgement of the influences of social organization became a presupposition of the concept.

Another reason for recognizing the social dimension of health is the importance of supportive or accommodating environments on elderly persons' well-being. In social contexts structured by one-size-fits-all arrangements, biologically atypical individuals are much more likely to suffer constricted capacity to function and to have their differences condemned as pathological than in societies that respond to individuals' biological distinctiveness with flexibility, inclusive access, and support. Elderly people also suffer deprivation of social as well as physiological functionality, as when aged individuals are retired from activities of community contribution and remanded to dependencies reminiscent of childhood. Further, for the old the resilience to maintain stability both in one's self and in one's social connections eventually slips away.

7.IS LEAVING LIFE A DUTY OF THE OLD?

Whether they are elderly, in mid-life, still children, or even not yet born, individuals who diverge from species-typicality owing to physical or mental deficits are vulnerable to being deemed too unhealthy and therefore burdensome for society to sustain. (Saxton 1998) Emmanuel is not alone in proposing that people in decline should eschew healthcare, or even be denied life-extending medical intervention if they do not refuse it themselves. For example, former Colorado Governor Richard Lamm achieved what likely was unwanted notoriety by recommending that old or very ill people not receive curative treatment. In 1993, the *New York Times* referenced Lamm's account of his policy proposal:

> After saying that society should be talking about the ethical implications, Mr. Lamm said, according to the excerpts: 'We've got a duty to die and get out of the way with all of our machines and artificial hearts and everything else like that and let the other society, our kids, build a reasonable life.' In his letter last month, Mr. Lamm wrote that he never said 'the elderly or the terminally ill have a duty to die,' and he added, 'I was essentially raising a general statement about the human condition, not beating up on the elderly.'(N.Y. Times editors 1993)

Although Emmanuel's focus is on the badness for the individual of old age's ineluctable decline, he also assumes a societally slanted perspective. He argues, for example, that in the eight years between 1998 and 2006 the percent of Americans age 80 or older who had a "functional limitation" nearly doubled, from about a quarter of that population to about half. Researchers recently have found, he adds as a warning against continuing such a trend, that there has been an "increase in the absolute number of years lost to disability as life expectancy rises."

We should note, however, that this conclusion is suspect, for there is no straightforward inference from having a functional limitation to losing a year to disability. That notion might make sense for working age people for whom functional limitation precludes employment. Of course many productively employed working age individuals have

functional limitations due to disability that, when properly accommodated, do not result in disengagement from work. Nor need retired people's similar functional limitations require their detachment from the activities of daily life if they too are properly accommodated. Conceptual confusion of the kind represented in claims about 'years lost to disability' undercuts the suggestion that somehow physical or mental declines associated with age rob society of old people's productivity. This could be the case only if people generally worked till they drop, but that is unusual in view of retirement plans commonly found in developed nations these days.

Critics of using medical knowledge to prolong old people's lives often invoke intergenerational social, political, or economic fairness as reasons for doing so. The first argument is that old people should get out of the way (and perhaps be got out of the way if they do not see their duty clearly) in order to enable younger people to assume leadership roles in families and in society as a whole. The second is that the costs of caring for the old are unfair to all who are not old. People are burdened with care for elderly parents, and society as a whole is burdened by the enormity of the cost of medical resources consumed by individuals who are old. (Hardwig 1997, Callahan 2013) Moreover, old people are no longer productive or creative; they do not contribute to others sufficiently to repay the costs of their care.

As for the first reason for elders to refrain from extending life or even from accepting care, old people who are as enfeebled as the argument makes them out are hardly likely to stand in younger, more productive people's way. As for the second reason, in weighing the fairness of the burdens of elder care, we can balance the years a parent spent in caring for a child against those a child may be called upon to spend while a parent needs care. As for costs for old people's medical care, there should be no doubt that medical costs are out of control. Treatment of elderly patients is a favorite site for the practice of unwarranted inflating of costs and plain fraud. (U.S. Department of Health and Human Services n.d.) But remedying problems arising from the structure of the health care system by sacrificing their access to care cannot be a duty of the elderly, who are not responsible for, or in authority over, how the system operates. The complaint that they are 'greedy geezers' inequitably demonizes elders by suggesting that their lives and well-being are less valuable than those of other people who also seek achievable cures.(Silvers 2013)

Yet another often advanced reason for limiting or eliminating elders' access to health care, broadly construed to include social as well as physiological support for well-being, is that old people already have enjoyed a full life and so should allow younger ones the same opportunities. Here an illegitimate inference from whole to parts may have been made. While the segment of the population that has reached old age may have accumulated more fullness of life than a similar number of youths, it is not the case that each member of the elder cohort has had a fuller life, or more than or even the same amount of opportunity as younger people. It is only recently, for example, that women have enjoyed more equitable access to fulfilling scientific and commercial careers, and disabled people to universities and workplaces. Elders who were the targets of biased exclusions in earlier years surely deserve full support – including adequate health care –

to build out in later years the careers and explore the enjoyments unfairly denied them earlier in life.

Is there any reason why all elders – not just those who suffered from discrimination in earlier life – should not enjoy the basic social services support they need to execute activities necessary to engage with daily life?

8.CONCLUSION

To be disabled is to endure unusual somatic or cognitive limitations that compromise one's executing some of the core activities of daily life. To be aware that one is old is to experience progressively increasing limitations of this kind, and, as well, to know that one has an inescapably foreshortened future. Thus, to be old is to be disabled, or to be at higher risk of becoming disabled than for populations at earlier stages of life.

No less than for disabled people who are young, an individual's being old should not invite or excuse disregard or other forms of discrimination based on disability. In the past half century the ubiquity of harmful bias based on disability, and the personal and social harm such discrimination does, has risen to world-wide attention. The United Nations Convention on the Rights of People With Disabilities (UNCRPD), adopted in December 2006, addresses many support systems important for daily living where, owing to their functional limitations, disabled people have historically been denied opportunity for equitable benefit and sometimes have been banned from any participation at all, owing to their disabilities. (United Nations)

In addition to general anti-discrimination provisions, such as equal recognition before the law (Article 12) and access to justice (Article 13), the UNCRPD's Article 25 assigns the right to people with disabilities to access health services of the same quality, range and standard as those to which nondisabled people have access. Old people are definitively individual with or at high risk of disabling functional limitations. The principle expressed by Article 25 thus assigns an equitable right to health care to the elderly despite their being at a stage of life characterized by functional decline. The text of Article 26, which provides for establishment of rehabilitation and social service support for people with functional limitations, explicitly establishes its application to old as well as young people, here again notwithstanding their late period of life.

In sum, from the global perspective the CRPD represents, their having reached the late period of the human life span cannot justify inferior medical treatment of elderly individuals, or withholding specialized services they are known to need. Nor, and this is the essence of disability rights, can disregard of the needs they have due to being old be excused by invoking the various deficits that come with old age. Old people are as deserving of good health care and other social supports as other humans, despite the foreshortening of their prospective attachment to life.

Inescapably, however, to be old is to be - by definition and thus more generally and more acutely than for the populations at other life stages – running out of time. Using Hume's

language for describing this experience, in addition to declining function, people at this life stage should expect increasing detachment from the activities and ambitions they previously engaged with in daily life. We explored the reasons for two apparently contrasting adaptive strategies for addressing this special limitation, Hume's tranquil acceptance and Emmanuel's self-imposed proposed escape.

We have construed them as articulating antithetical adaptive strategies, as if the testimonies of the two philosophers were on a par. But Hume extolled the quality of his actual day to day lived experience during the last period of his life, while Emmanuel condemns the quality of a life he presumes he will experience but has not yet lived.

Unlike Hume, who proclaims his indifference to experiencing an elevation of his fame, Emmanuel's model for an acceptable way of living remains firmly anchored in, rather than distanced from, his current self's ambitions. Further, and perhaps most telling, his current bias against old people, whom his present-day self disdains, infects his judgment about the value of his future self, and almost every other aged self – both present and future – as well. Of course, he leaves his future self some ways out. pPerhaps he will be one of the very rare individuals he acknowledges are able to maintain their social value despite the functional deficits attendant on great age. Or perhaps he will have changed his mind when he perceives old age as an "insider," the standpoint from which Hume's evaluation of the quality of his late life is made.

Adaptive valuing that furthers injustice does not deserve our assent. Bias against the elderly fuels fraud that victimizes them financially and body-bruising, self-confidence crushing abuse. Expressions of bias can have this result, even if the agents of this kind of thinking do not themselves execute patently wrongful acts. How much better, before one's own late life sets in, to refrain from adapting one's valuing to biased-fed fears so vehemently as to insist that living as an old person generally must be worse than not living at all.

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