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3938/1 01/09/09

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ISBN 978-84-692-0777-2
Edita: Fundació Víctor Grífols i Lucas. c/ Jesús i Maria, 6 - 08022 Barcelona

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INTRODUCTION

One of the purposes of ethics is to ensure that individual benefits and the common good are in harmony. Individuals do not live in isolation but as a part of a wider society, and they have to share goods and opportunities in a way which is fair and equitable to ensure that nobody is denied those things which are deemed essential for all. In health, the problem of reconciling individual desires with what should be shared by and accessible to all is exacerbated by the fact that, while our demands grow inexorably, the resources to fully satisfy these demands are scarce. Professor Daniel Callahan dedicated his Josep Egozcue Lectures, in 2007, to this difficult issue, considering how to achieve a sustainable medicine in the context of a market economy which does not measure progress in terms of equity but rather in terms of supply and demand.

Callahan reconsiders the notion of progress, arguing that this cannot be seen as «unlimited». Humans have a finite existence, and we are inevitably destined to age and die, something which it would be neither realistic nor intelligent to ignore given that the renewal of life is one of the few natural conditions upon our existence. Human life is finite and medicine should be too, and should therefore not include among its aims the attempt to abolish the finite nature of life. This perspective should lead us to reflect on the meaning of technological innovations and the impact of these on the economy and on the equitable distribution of resources. We should not do everything which is technically possible. The imperative of equity should govern the technological imperative and not the other way around, as so often happens.

To the above comments on technological limitations we should add that the market, on its own, is not governed by criteria of fairness. Its most immediate goals are to produce a healthy profit and loss account and to maximize returns. This is why we need a universal health system which subordinates the private interests of the economic system to the general interests which identify health as a basic good and as a right which is guaranteed to all citizens. Callahan is highly critical of the health system in the United States and

contrasts it with the systems in Canada and Europe, where coverage is effectively universal. A welfare state which provides citizens with adequate healthcare is based on solidarity between individuals, underpinned by laws designed to ensure that nobody is excluded from the basic right to health protection.

Callahan stresses the importance of a state which is genuinely committed to protecting people's health, and the implementation of whose principles should be based on the assumption that we have to set limits to technological innovation. Limits to technology, on the one hand, and measures to increase the birth rate, on the other, a problem which would have been unthinkable only a few years ago but which today is becoming a serious one, particularly in some European countries, including Spain. Callahan's final lecture directly addresses the issue of the falling birth rate: its causes and possible consequences. He concludes by arguing that the trend towards an ever older population should be the focus of more urgent attention by government, as «the longer we wait, the more serious the problem will become».

Victoria Camps
President

Medical Progress: What Should We Seek and What Should We Limit?

Nothing is so common these days than talk of the need for health care reform. There is hardly a country in the world where one can not find such a discussion, and often heated debate, about the future of its health care system. One might indeed see the need for reform as a kind of chronic disease of modern medicine and health care systems. Moreover, once some reforms are put in place, one can be sure that there will soon be a call for still another round of reform. Almost always the need for reform centers on the cost of health care, and how to manage and control those costs. And nothing seems to work for very long.

What is the cause of this chronic disease? Part of it is surely political, a function of changing parties and ideologies with different agendas to put in place. But a more fundamental reason is the nature of modern medicine, and a medicine that must cope with a changing demographic scene. There are three major reasons for the constant stress.

One of them is the fact of aging societies, a reality true of all western developed countries. There are a growing number and proportion of elderly, with even greater numbers and proportions expected over the next few decades. Since it is commonly estimated that health care of those over 65 is approximately four times as much per capita as those under 65, further financial difficulties can be expected as the population ages and the proportion of elderly people increases. Spain, along with other countries with a low birth rate –as I will discuss in a later lecture– will be under a particularly strong threat.

Another reason is the constant introduction of new, and usually more expensive, technologies –notably new drugs and devices– and the intensified use of older technologies. And still another reason is the increased public demand for good, and for that matter even better, health care. Modern people have come to expect constant improvement in medicine and health care. What was adequate care a decade ago is rarely considered adequate any longer; and this year's level of care is not likely to seem adequate a decade in the future.

Of all these reasons, however, I believe that medical progress and technological innovation are the most important. Historically, the idea of medical progress is comparatively new. The medicine of the Hippocrates era, some 2500 year ago, had no such idea. Some diagnostic skills and the provision of some comfort was all that the physician could offer, and that situation continued until well into the 16th and 17th centuries. The great change in outlook came with the speculations of Francis Bacon and Rene Descartes. They saw the possibility of using scientific knowledge to understand human biology and to conquer disease. Descartes even raised the possibility of a great lengthening of human life.

But it took some centuries more before those speculative possibilities became realities. By the second half of the 19th century, scientific medicine was hitting its stride with constant new discoveries and some clinical applications. Death rates began to decline, average life expectancy increased, and greater understanding of the role of public health –particularly diet, clean air and water, and good sanitation– emerged. By the middle of the 20th century, the idea of progress through scientific research and the possibility of constant technological innovation was well established.

Research budgets increased in dramatic ways, the medical and device industries well understood that people would pay for constant progress, and the role of health care as a major social institution and focus of government concern became universal. But by the 1960s, even as the excitement of medical progress grew, the early signs of financial stress began to appear. By the 1970s, worry about the rising cost of health care became a concern in every country. But despite that concern and various efforts to do something about it, costs continued to rise, and they continue to rise to this very day. Health care cost projections out into the future, 20, 30, or 40 years from now, are everywhere a source of alarm.

Medical progress has brought us wonderful rewards. We live longer and healthier lives. Most of our babies and their mothers survive childbirth, most of our young people can expect to become old people, and most our old people can expect to live longer and in better health than their parents and grandparents. It is hardly any wonder, then, that medical progress and technology are revered.

Yet there is that cost problem. The greater the progress we make the more expensive the whole venture becomes. As with the rise of affluence more generally, however much we get is never as much as we would like. In the United States the estimate is that from 40% to 50% of cost increases can be traced to the technological factor, and I suspect something similar may be true in Europe. The net result of the technologies and other factors in the United States has been an average general system-wide cost increase of 7%-10% a year for the past several years, and with no end in sight. European countries I know are under severe costs pressures as well, even if perhaps not so much as in the United States.

By virtue of greater government control of health care spending, annual percentage cost increases have been half those of the United States. But, even so, they are usually greater than the increase of general inflation, and the percent of Gross Domestic Product (GDP) going to health care almost everywhere steadily increases. In Spain it has grown from 7.2% in 2000 to 8.1% in 2004. That kind of growth is something to worry about.

What is to be done about this problem? It will simply not be possible for health care systems in developed countries to continue down this path. Unlimited increases in health care spending are not sustainable. The major threat of escalating costs is to undermine the ideal of equitable access to health care, which most European countries have realized over the decades. A lesser threat, but not trivial, is that of constant legislative struggles about health care, rationing of an open and covert kind, waiting lists, and increasing public dissatisfaction with health care. Ironically, the actual health of a population may be at a historical high point. But since the expectation has come to be that of constant improvement, a failure to improve will no doubt be taken as a sign of failure.

Many efforts at reform are underway, and I will simply mention some of the most prominent: increasing use of co-payments and deductibles, privatization of parts of health care systems, long waiting lists for elective surgery and other forms of non-emergency care, the use of evidence-based medicine to better determine which treatments are efficacious, and various forms of rationing, often unacknowledged.

All of those efforts are important, but I want to suggest that they are not likely to work much better in the future than in the past –and that, if we limit ourselves to them, the reform crisis will continue, and even get much worse. I call all of those methods administrative and organizational; that is, an effort to change the system in some clever way to deal with the cost problem.

But, given the nature of the problem, there is no way we can be that clever. We must think about the problem in a much deeper, even more radical way. We need to change our ideals and some of our modern values about medicine and health care –and not simply try to find better ways to reorganize existing systems, important as that is.

We need what I call a «sustainable medicine,» and the key to such a medicine requires a rethinking of the idea of medical progress and constant technological innovation. By a «sustainable medicine» I mean an idea, or even vision, of medicine and health care that aims to be (a) equitable and accessible to all, (b) affordable to national health care systems, and (c) equitable and affordable in the long run, not simply for a few years.

I take the notion of «sustainability» from the environmental movement, one of whose aims is to have an earth that can sustain human life of a good quality for the indefinite human future, one that knows how to avoid ruining the atmosphere and the earth in ways that would harm future life. I am looking for an analogous idea in health care.

We do not have at present sustainable health care systems in any country. Constant medical progress, adding to costs, and aging populations, also adding to cost, guarantees they will be unsustainable –and thus guaranteeing a threat to universal health care and an affordable medicine. If medicine is unaffordable, it can not be equitably distributed; only the wealthy will be able to get the best health care, and everyone else will have to settle for less.

I have already indicated why I do not believe that organizational and managerial reform can cope with the present unsustainable situation. Nothing less than some fundamental rethinking is needed. If there is to be a sustainable medicine, we will need to formulate in some fresh way the idea of progress

that drives the technology costs and feeds public demand and, along with that, come to accept the idea that sooner or later we will have to reach some plateau of both progress and thus health care spending.

The western idea of medical progress is what I call the «unlimited model» of progress. By that I mean an idea of progress that sets no limits on the improvement of health, that is, the reduction of mortality, the cure of all disease, and the relief of all medical miseries –and the notion of what is a medical problem itself constantly changes, by the process known as medicalization. It is «unlimited» in the sense that, however much health improves, whether in reduced death rates or sickness rates, it will never be sufficient to satisfy human demands –and thus further progress must always be pursued. If the average age of people in our doctor's offices or in hospitals was 100, those people would be saying «help me doctor, save my life, reduce my pain and suffering, help me to be healthy once again.» An unlimited idea of progress invites that kind of unbridled desire, which has no boundaries, no limits to our aspiration.

But an unlimited, infinite, vision can not be paid for with finite funds. We need instead to redefine progress in a way that will be affordable in the long run, and thus equitably accessible to all, and which will have, as its model, a finite vision of medicine and health care. By a «finite vision» I mean one that does not aim at the overcoming of aging, death, and disease, but limits their effects to old age only, and which simply tries to help everyone avoid not death itself, but to avoid a premature death and to live lives with a decent, even if not perfect, quality of health.

The vision of a finite medicine, with limited goals and aspirations, would have to include a number of ingredients:

First, it would have to heavily shift research and medical care in the direction of health promotion and disease prevention. That would mean putting considerably more research money into an investigation of those health behaviors most likely to bring about disease and illness and a focus on how to change those behaviors. Billions of dollars have recently been spent on mapping the human genome. Comparable research sums need to be spent on understanding health behavior: why is it that obesity is increasing almost everywhere and what can be done to change that trend? Why is it that so many people continue smoking in the face of the evidence that smoking is a lethal habit? Why is it so hard to get contemporary people to exercise?

We do not really know the answers to questions of that kind, much less how to change such behaviors. But we need to find answers. What we can not do is to continue throwing high technology medicine of an ever more expensive kind at sick people. We need to better understand how to keep them well in the first place so that they do not need, or want, those technologies.

Second, we need to find good ways to compare expenditures on health care against expenditures on other socially important goods, such as education, job creation, and environmental protection. It is well known, for instance, that the higher a person's education level the more likely they are to have better health as well. As for jobs, it is also well known that those without work, or doing work well below their talents, are at much greater health risk than those who are adequately employed. But in many countries health care is treated as if it is something special, so much so that it ought not to be compared with other expenditures. But, even for the sake of health, there are useful ways of spending money that have nothing to do with the direct delivery of health care. And beyond that point a well-run, balanced society needs to have some good sense of its most necessary priorities; and health care may not always come out at the top of the list.

Third, we need the public to understand that rationing is now and will always be a part of any health care system. No system can give everyone everything they need in the name of better health. Our aspirations will always exceed our resources, particularly when medical progress itself has the result of raising public expectations of what medicine can do for them. A survey some years ago in the United States found many more people now believe they are in worse health now than people surveyed 30 years ago. Yet in actual fact their health was far better. It is just that their notion of what counts as «good health» has changed. We want more, expect more, and complain more loudly when we don't get it. And when we do get it, we quickly raise the bar, wanting something still better. Thus one way or another ration-

ing will be needed. That issue needs to be discussed openly, which legislators and health officials are nowhere happy to talk about. But if rationing is to be fair and reasonable, then it must be done with the knowledge and general consent of those being rationed.

Fourth, our technologies must be much more toughly evaluated, and preferably before they are released to the public rather than afterwards. Mention has already been made of evidence-based medicine as one technique for controlling costs. But evaluation of that kind is ordinarily aimed only at the efficacy of a diagnostic or therapeutic procedure, not at its likely economic impact. But that impact needs to be evaluated as well, and it should be done by the manufacturers of the technology, whether drugs or medical devices. The companies are now forced to evaluate new drugs for their safety and efficacy, and it would be thoroughly appropriate for them to evaluate their economic impact on health care. There should of course be government oversight of such work, paid for by the companies but verified and approved by government.

Only if the evaluation shows that the technology will not significantly raise costs, or do so only for exceptional technologies, should governments be willing to pay for them. This would be a very tough standard, but much better than the present situation, one that sees new technologies more or less dropped into health care systems uninvited. In the future they should be asked in, but only if their developers have shown they are worth the money and not just good for our health.

Finally, and most fundamentally, a change from an infinite to a finite model of medicine would have to embody a different attitude toward human aging and death. Even if it is well understood in daily medical practice that people get old and die, that is by no means the case in the medical research community. In that community every lethal disease is a candidate for a cure and the phenomenon of aging often treated as some kind of preventable condition, itself a kind of disease. Few people want to die and not many welcome aging. But those realities are part of the human life cycle, which has yet to be repealed despite a great deal of talk about doing so.

Medicine must increasingly shift its focus from length of life to quality of life, from the cure of disease to caring for those who can not be cured. A medicine that keeps people alive too long, burdening their life with technological treatments that may bring them much pain with little health gain, is not a decent and humane medicine. Two hundred years ago most people died of infectious disease, ranging from plagues to diptheria. Most interestingly, when people got sick from infectious disease they either died quickly, within a few days, or they recovered; and when they recovered they usually had few lingering symptoms. Now lives can be kept going for many years in the presence of disease, whether cancer or heart attacks or Alzheimer's.

Naturally, those who died of infectious disease two centuries ago died much younger. We now have the advantage of living much longer, but also our dying takes much longer, extended by chronic diseases that can be partially controlled but not cured. Now we can live to be 80 or 85 or 90, but we are likely to do so with a number of chronic conditions that leave us sick but not dead. The average old person with a terminal disease in the US will have an average of 5 serious medical conditions, compared with only one for someone not dying.

Perhaps it is a good trade off that we now live longer, but spend more of our later years burdened by disease, though I sometimes wonder about that. Would I prefer to have died at 45 from small pox to avoid death at 85 from congestive heart failure? Well, I am not sure about that, though I am glad that small pox was cured. Would I prefer to die now, at 77 from cancer or kidney failure, or live into my 80s with a 50% chance of contracting Alzheimer's disease? Ironically also, infectious disease has not actually been conquered. Because of new diseases, such as AIDS, and more and more infectious conditions resistant to antibiotics, and an increase in hospital deaths from infection, the rate of deaths from infectious disease is as high now as it was 40 years ago.

In the end, in asking that we reconsider the idea of progress, I am not asking that we stop progress, but only that we think about what it is giving us as its general direction. Its present direction is not sustainable, focused as it is on

cure and cure by high-technology medicine, usually of a costly kind. No matter how much money we spend on combating aging and death they will win out in the end. Medical progress is a bit like exploring outer space: no matter how far we go, we can go even further.

With space travel the economic limitations of unlimited exploration soon became obvious: no more moon walks, much less manned trips to Mars. We have settled instead on space shuttles as an affordable, even if limited, means of exploring outer space. And fairly recently both the airline industry and the airplane manufacturers decided that supersonic passenger planes were just not economically viable. We need analogous insight into unlimited medical progress. We can not afford everything we might like, even life itself.

By calling for a change in our vision of the future of health care, I am simply asking that we be reasonable in our expenditures and our expectations. No one wants to live with a health care system in constant economic turmoil, or with one that excludes the poor from all of its benefits. Only a sustainable health care system is likely in the long run to be tolerable. There will be less technological progress, some people will not live as long as they might have desired, and many medical desires may go unfulfilled. That may seem a high price to be paid for sustainability. But I believe that our present unsustainable systems carry an even higher price, threatening justice and social stability. Less is often better than more in human life, and that may well be the case with health care.

Meanwhile, there is a consoling thought. Expert estimates are that about 60% of health status improvements over the past century have come from improvements in the social and economic conditions of life, and only 40% from improved medical care. That trend is likely to continue. It means that, even if high technology progress is slowed and rationed, people are almost certain to live longer lives in the future and in better health than at present. One of the most interesting differences between American and European health care is that there is much more technology available to Americans, more scanning and imaging devices, more advanced heart surgery and expensive cancer treatments –and yet European health outcomes are better than ours. More technology and greater access to it, in short, does not necessarily bring about better health.

One of the most important developments in recent health care has been not only the increasing number of those who live into their 80s and 90s, but how many of those who do so have not survived because of advanced medical care. While there has been a steady increase in the age of those undergoing advanced technological treatment, particularly in surgery, there has been a decline in acute care medicine for those over 80. Moreover, those who make it to the age of 90 are likely to have had good health through much of their life, avoiding doctors, hospitals, and intensive care units. The long standing hope of a «compression of morbidity,» that of a longer life in good health followed by a quick death is happening with more and more people. Of course not everyone is so lucky, and for most of us a slow decline is still most likely.

I want to conclude by taking up the two questions posed in the title of my lecture: What should we seek? What should we limit?

We should seek:

- To go from being a young person to being an old person, but not to live indefinitely.
- We should seek good health care for our children to make certain that happens.
- We should seek to live our lives in as healthy a way as possible: follow a good diet, control our weight, do not smoke or drink to excess, and exercise regularly.
- Avoid going go doctors excessively: they are trained to find something wrong with you, and if you give them enough chances to do so, they will –follow the model of those who live to be 90, which seems to mean having little to do with medicine.

- If, despite our best efforts, we become ill, then we should not expect miracles from our doctors, nor expect them to always keep us alive with the most expensive technologies.
- A health care system that treats everyone alike and distributes good care equitably.
- We should seek a society that provides everyone with a good education, makes jobs available, treats everyone fairly, and takes good care of the poor: a healthy society needs much more than a good medical care system to keep everyone in good health.

What We Should Limit

- Specific efforts to constantly extend life expectancies –an average age of 75-80 is a long enough life to experience most of what a full life offers–.
- Efforts to find a medical solution to all of life's problems, whether the solution be drugs or physical enhancements.
- Efforts to constantly increase the supply of new technologies, limiting them only to those that show significant benefits at an affordable price.
- We should be wary of utopian medical ideas: having exactly the kind of children we want; living lives much longer on average than we now live; developing drugs that will help us eliminate some of the necessary suffering of life, such as grief.
- Any scientific, medical, or commercial efforts to persuade us that nothing is more important than more and better health. How we live with and accept our finitude is as important as having good health. Good health is not much good in a bad society. Illness can be better endured in a good society.

- Medicine will surely continue to make progress, even if there should be a more limited set of goals as it is pursued. Nothing in human life stands still, and neither will medicine. But that progress must always be seen in the context of other social needs, also important to human welfare: food, clothing, shelter, jobs, economic security, the welfare of family, national defense, and now environmental protection. Health is an important human good and the provision of health care an important social obligation. But is not the only social obligation.

Medicine and the Market

To enter the jungle of medicine and the market is not only to encounter many choking vines and dense undergrowth, but also to move through a climate alternatively marked by cool, technical winds and hot, ideological cyclones. The topic of medicine and the market touches on some of the oldest and deepest human questions –what, for instance, is the appropriate place of self-interest in human communities, and particularly in the health care community? At the same time it forces consideration of a difficult range of technical questions –at what point, for example, does a co-payment for a drug reach a level that it helps control health care costs but is harmful to the health of patients on whom it is imposed?

In my experience, the greatest difficulty in talking about medicine and the market is that, for most people, it seems an either/or choice: either love the market or hate it, either see it as the panacea for troubled health care systems beset by government bureaucracy, or as a mean-spirited devil designed to destroy the very idea of equitable care. Let me put my own general conviction out on the table. I am convinced that a government –run or government-regulated health care system mandating universal health care is the best kind of system– but that there is some room for carefully considered market practices within, or aiming at, and supportive of such care. Moreover, like it or not, it is almost impossible to imagine any universal health plan politically succeeding in any country, and particularly my own, unless it is clever enough to work in some market ingredients in a way that helps such a plan, or at least does no harm to it.

In the European and Canadian health care systems we have, so speak, a long-standing natural experiment with universal care, extending over decades in most places, and a century in a few. That experiment displays a range of outcomes and qualities that by and large are superior to the jerry-rigged American system that mixes the public and private sectors. The European experience also shows that, if used carefully, there are market practices that can serve the ends of universal health care. It is not necessarily either/or after all. Our problem in the United States is a kind of romantic view of the market that makes it suitable for just about any human activity, and most importantly health care. If there is a clear devil with nasty horns, it is government.

As our early President Thomas Jefferson once said, «the best government is the least government.»

There is, moreover, a peculiar feature of the difference between Europe and the United States. When there are tensions and economic difficulties in the American health care system, heavily invested in market practices, the tendency is to look to an increased role for government as a way out. In Europe, heavily dependent upon government, the tendency for over two decades has been to look to the market as a way out.

I want in this lecture to see if some sense can be made of the medicine-market debate, and to ask how the issues are best framed to lead to a fruitful argument –which I do not believe we have at present, at least in the United States. The debate seems to more quieter and more low-key in Europe, but as health care costs continue to rise and more pressure is put on health care systems, more people will advocate for more of a market emphasis to deal with the problem.

A place to start is by distinguishing among three different approaches to the market, one focused on the market and the role of money in medicine and health care, another on the market as a neutral instrument of health policy efficiency, and still another on the market as an important bulwark of democracy in general and of freedom of choice in health care in particular. While these three approaches can be distinguished, they overlap at many points.

Medical Commercialism and the Market

At the center of a focus on money and commercialism is the tension between the traditional altruistic values of medicine and the centrality of self-interest as a feature of market thinking. Two quotations nicely bring out that tension.

One of them is from Plato, in *The Republic*: «The physician, as such studies only the patient's interest, not his own….All that he says and does will be with a view to what is good and proper for the subject for whom practices his art.»

The other, better known passage, is from Adam Smith's 1776 book, *Wealth of Nations*: «It is not from the benevolence of the butcher, the brewer, or baker, that we expect our dinner, but from their regard for their own interest….nobody but a beggar chuses to depend chiefly upon the benevolence of his fellow-citizens.»

A long stream of voices over the years have worried about the impact of commercial values on medicine –the loss of Plato's altruism– most recently the editors of the *New England Journal of Medicine* (e.g., Arnold S. Relman, Marcia Angell, and Jerome P. Kassirer) as well as such distinguished physician educators as Edmund D. Pellegrino. They worry about physician entrepreneurs (opening for-profit clinics, referring to patients as «consumers»), the mercenary interests of drug and device manufacturers and their sway over medical research and practice, direct-to-consumer drug ads, and the way a combination of debt and exceedingly good money lure many medical students into medical specialties.

A New York ophthalmologist who advertises on the local New York CBS radio station that he has performed 30,000 laser eye surgeries is vivid exemplar of the crassly commercial model in medicine. Nor is it easy to forget the historical resistance of the American Medical Association in the late 19th and almost through the end of the 20th century not only at first to group practice of any kind, but later on to a more persistent and effective opposition to universal health care, a.k.a. «socialized medicine.» It the medical establishment's way of attempting to maintain economic control over medicine, something they feared government would take from them. Even excessive altruism was treated as a threat.

Yet there is some reason to resist too sharp a line between commercialism and altruism. Plato also recognized in *The Republic* that, as one commentator put it, the physician was even then «something of a businessman.» As long as physicians sell or barter their services to patients as they have always done, commercialism is present (which can run the gamut from benignity to cupidity). There can be a fine line between a sense of entitlement for hard work and valuable services and sheer greed. For his part, Adam Smith well understood that the market requires a morally supportive culture, one that works to curb excessive self-interest and to instill the virtues of empathy and concern for the welfare of others. That does not always happen.

Of course the problem of money and commercialism goes well beyond doctors and patients. The American health care system as a whole is a combination of for-profit and non-profit hospitals and clinics, insurance companies, the drug and device industry, and companies selling a wide range of ancillary goods and services. The simple fact is that there is money, and good money, to be made in the health care industry, and it serves many purposes other than health: profit, jobs, civic prestige, fine stock market investments. When there is a threat that a community hospital might shut down, there is often as much anxiety about the loss of jobs as about threats to health care. There is not much in American life that is not marked by aggressive commercialism, and health care is right up there with investment banking as a source of the good (economic) life.

The Market and Efficiency: Instrumentalism

As a profession, health care economists have an important role in health policy, bringing to bear a discipline most commonly oriented to means not ends, efficiency not equity, and empirical research rather than high theory. Now those are generalizations and, in reality, many health care economists do worry about equity. But the discipline itself nudges economists strongly in what I call an instrumental direction. By that I mean a disavowal of professional competence to serve the inner culture of medicine, to determine the proper political and ethical goals of health care, and to pass judgment on the personal conduct of physicians. Their questions comes to such as these: If one (a nation, a community) has decided on a particular kind of health care system, how might it best work –with what balance between government and market– and which modes of organization are likely to be most efficient? How might financial incentives be used to influence physician and patient behavior for goals of cost or quality?

While there has been a market debate in Europe, it has been far less ideology driven and rhetorically charged than in the U.S. I attribute those traits to a focus by health care economists there on which particular market practice and tactics are most likely to make universal health care systems to work better, whether to control costs or to enhance quality. What contribution could competition make? How much and what kind of price control will be effective in controlling costs without stifling research and innovation?

My impression also is that European health care economists are more willing than their American counterparts to speak out on the need for equity (not understanding that to be outside of their discipline). A European health care economist who called for a dismantling of a government-run system and turning it over to the private sector would be a striking anomaly; but more than a few with that view can be found in the U.S. On both continents, however, the name of the economic game is the demand for solid empirical evidence to back claims of efficiency, quality, and cost control.

Ideology and the Market: Choice and Democracy

I now come to that group I will call the «politicals.» That term characterizes a mixed political and policy group who see the market not just as an instrumental means to achieve efficiency, but even more as a key ingredient of democracy and political freedom. Its economist heroes are Friedrich A. Hayek and Milton Friedman, but it also includes an influential group of neoconservative intellectuals and institutions (e.g., *The Wall Street Journal*, *the American Enterprise Institute*, *the Heritage Foundation*), and most importantly of late President George W. Bush and most Republican politicians.

Their core position (as I read it) is that, in the organization of health care, market and personal freedom are more important than equity (though they never speak that bluntly), and that the private sector will produce better health care than government. Some would add that, if the market is given a full chance, it could eventually lead to de facto universal coverage. Just as the free market is the economic engine of prosperous and productive societies, raising the standard of living for all, so also can it be the foundation of a good health care system. Its main argument is with those who believe that government is the crucial ingredient of a universal health care system, and government bashing –inefficiency, bureaucracy– is a standard refrain of its rhetoric. And that rhetoric, unlike the cool style of health economists, can be hot, sometimes even more than the heat of pro-government advocacy.

My surmise is that because for the politicals the market is seen to play a crucial role in a good society (any good society), its penumbra will affect the culture as a whole and its various political parts. If the market is good for societies in general, it is no less good for its various sub-sectors, including health care. The market as a value is, so to speak, politically and morally supercharged.

Intertwined Values

While the three approaches to the market and medicine I have characterized are distinct, they interact with each other. By and large those worried about the commercialization of medicine and a corruption of its altruistic ideals see market values as the deadly virus. Only a government run, well integrated single payer universal health care system can deal with such a virus; and, preferably, a system where the physician is a salaried employee (as in the Kaiser system or the British National Health Service). That would shut out entrepreneurial physicians, an excessive use of well reimbursed technological procedures of marginal benefit, and a too potent role for pharmaceutical detail men touting the newest and latest drug. Those in this group make some use of economic data, but on the whole rely on clinical information and experience.

It is unclear to what extent the health economists (of the instrumental kind) affect the thinking of those concerned with medical commercialization as a moral concern or those with a political agenda. Some studies in the aftermath of the failed 1964 Clinton health care plan indicated that economists

were divided on universal health care and the role of the market. The distinguished economist Victor Fuchs concluded that, because of their own internal divisions, economists had little influence in that debate.

While I have not tried to document the influence of health care economists in the market debate, my impression is that those worried about the commercialization of medicine have their own reasons and academic sources, not making use of the mainline instrumentalist economists to buttress their views. For their part, the politicals have their own cadre of economists, using them mainly in support of their own positions. The politicals appear to have little interest in the problem of a commercialized medicine. Indeed, because of their proclivity for a privatized medicine they would not be expected to worry much about it. Actually, neither the instrumentalist economists nor the politicals pay great attention to the impact of market practices on the culture of medicine or medical professionalism.

I have cited these three approaches to the relationship between medicine and the market to make a simple point: there is more than one way to think about the market. While there are some overlaps among them, the problem of the market and medicine can be seen in very different ways. For those concerned with the culture and professionalism of medicine, there is little in a market approach that attracts them; it mainly repels them. While they are prone to support universal health care, it is possible that they would accept some mixed public-private system as long as it supported the traditional values of medicine.

At the other end of the spectrum, the politicals are the most broadly ideological. It is not as if they have examined medicine and health care and then determined that a market approach would be best. They start instead from a belief in the value of the market and then assume that it will be valuable in health care. And for them the market means a rejection of any but the most minimal governmental role (a small, not large, safety net), an embracing of a wide range of market practices, and –most importantly– an embrace of freedom and choice as the highest moral values. By virtue of that last commitment, there is little anxiety about market failure or a lack of universal coverage. Freedom is a value that trumps all others and the fact that it can create its own problems is no reason to reject it (much as someone committed to democracy would be little swayed to reject it by evidence of the harms that democracy can bring, plentiful though they can be).

The instrumentalists are (at least in principle) ideologically neutral and committed to gathering evidence about the effectiveness of various forms and systems of health care. I have been most influenced by their research, a philosopher who has come to like numbers and data, not just well-honed moral arguments.

Establishing Standards of Judgment

If it is the case that there are three ways of thinking and talking about the market and medicine, does that mean there can be no unified way of doing so? Not necessarily. A full consideration of medicine and the market should encompass each of the three realms I have described: the realm of medical culture and professionalism, of empirical evidence and market theory, and that of ideology and values. Put another way, we should want a health care system that (1) preserves and encourages the traditional values of medicine and the highest standards of professionalism, (2) that in its economic features is based on the most reliable and well-grounded economic theory and evidence, and (3) that its ethical and value foundations works to balance individual good and common good within health care, and no less to balance the well-being of the health care system and all those other collective goods necessary for a decent society (much less commonly considered in health care analysis).

Varieties of Health Care Systems

There are essentially three forms of health care in developed countries:

The American System. The characteristic mark of the American system is its fragmented system of organization, administration, and financing (which

many think of as no «system» at all). Its organization encompasses fee-for-service care, for-profit and non-profit group medical practices of many kinds, for-profit and non-profit hospitals and clinics, and government run hospitals and medical services. Its administration can be found at the state level (and within that level at the county and municipal level) and at the federal level, and within the private sector at the corporate level. Its financing comes from the Federal government, state governments, and the private sector (for employee insurance). Lacking any system of universal care, there is no organized effort to guarantee decent health care for all; and, thus, a large number of uninsured. The combination of these ingredients almost guarantrees that the U.S. spends the most money per capita on health care and a larger portion of its GDP on health care than any other nation.

The European and Canadian Systems. While there are a wide range of differences among European and Canadian health care systems, the common thread running through them is a commitment to universal and equitable care and to the value of solidarity as its foundation. No attempt can be made here to summarize the variety of European systems or the Canadian system. However, a few important categories can be noted.

One of them is the difference between the Bismarckian and the Beveridge systems. The former –called social security systems– is traceable to the late 19th century and the regime of German Chancellor Otto von Bismarck. It consists in each country of a number of private insurance plans but plans closely regulated by the government. The plans are funded by mandatory employer and employee contributions, and buttressed by government payment for the health care costs of the elderly and the unemployed. Some degree of additional private insurance is available in such systems. France, the Netherlands, Switzerland, Belgium, Germany and Israel have social insurance plans.

The Beveridge systems, by contrast, are supported by direct taxation and the systems as a whole are directly run by the government, usually some combination of local and central government management. Private insurance is also available for extra services and avoidance of waiting lists. The tax-based systems include the United Kingdom, Canada, Denmark, Sweden, Italy, and Spain.

If all countries, whatever the system, provide or mandate universal care, they exhibit different attitudes toward the market. In our book *Medicine and the Market* we discriminate among three such attitudes: a strong, supportive stance toward the market (the United States), strong resistance to market ideas (Canada and the UK), and a permissive attitude (the Netherlands and Switzerland). In the case of the UK, however, «internal markets» have been employed to improve the efficiency of the National Health Service, even though a general resistance to market ideas has remained strong. In the Netherlands market competition among the insurance providers has been encouraged and managed competition pursued in various parts of the system. It is worth noting that two countries, New Zealand and the Czech Republic, embraced a wide range of market practices in the early 1990s, only to decide that they had been a mistake, reverting back to Bismarckian systems.

Though there is a range of responses to market ideas in Europe –mainly centering on its possibilities for increasing efficiency and controlling costs, and not ideologically charged as in the U.S.– some market practices can be found everywhere. No health care system in the world is purely government run or purely market centered; all display a mix. As an aside, outside the scope of this paper, I would note that India and China, however, provide no safety nets for hundreds of millions of their citizens and thus one can say that, de facto, they are market-based: if one can not pay up front for care, one can not get it. But that neglect seems more a matter of indifference to human suffering than an explicit embrace of market theory.

Evaluating Market Practices

It is useful to divide the impact and value of market ideas into two categories, the tactical and the strategic. The tactical comprises a group of discrete market practices of a kind that are ordinarily used to advance market values. The strategic category is meant to evaluate health care systems as a whole and the relative strength of market-oriented-versus government-oriented systems, each to a greater or lesser extent making use of market practices.

Six market practices are the most commonly employed:

1) *Competition.* Competition is at the heart of market theory applied to health care: competition among the providers of care leading to greater freedom of patient choice about the cost and quality of care. While there can be and has been competition on quality of care and the provision of various amenities, its most common use in a market context is that of price competition. In that respect, there can be price competition among physicians for patients (not common anywhere), competition among insurers within universal health care systems (a feature of European Social Health Insurance systems and American health care insurers), competition among providers (such as HMOs), competition among hospitals and clinics, and competition among vendors selling everything from drugs and MRIs to hospital bed sheets.

2) *Cost-Sharing and Co-Payments.* While not ordinarily thought of by the public as a market practice, they are, and their use is endemic in all health care systems (particularly co-payments) –the latter is in fact the most widely used market practice. Their aim is to reduce the costs of health care providers, shifting some of them to patients, and to force patients to take cost into account in deciding on medical treatments. American health care insurers and HMOs make use of deductibles and co-payments, but so also do European systems, even though they frequently waive them for elderly, poor, and other groups of patients.

3) *Private Health Insurance.* There are many things that could be said about private health insurance but I will look at just one. In developing countries it has a special salience: will it suck talent, resources, and political support from government programs –not typically a problem in affluent countries. Canada does not allow parallel private health insurance for the two major tracks of its universal care program (called Medicare), hospital and physician care. Most European countries do allow such insurance and Canada has in recent years undergone a considerable debate on the matter. The Supreme Court of Quebec declared in 2005 a prohibition of parallel private insurance for hospital and physician care to be unconstitutional for that province, but it is not clear whether or when other provinces will follow. In most universal care countries private insurance is used for co-payments, better amenities and faster service and, in Canada, private insurance is allowed for pharmaceuticals, not covered under Medicare in any ample way.

4) *For-Profit vs. Non-Profit, Medical Savings Accounts, Physician Incentives.* I have grouped these last three market practices together because, as a group, they are found mainly, but not entirely, in the United States. For-profit vs. non-profit clinics and hospitals exist in many developed countries but seem to have been studied mainly in the United States. Physician financial incentives for the quality of their care are primarily an American phenomenon. Medical savings accounts are being pushed by the Bush administration though they have also been used in South Africa and Singapore –though the former eliminated them in 2005.

The Impact and Value of Market Practices

An examination of each of the six listed practices produces mixed results. The evidence on the effectiveness of *competition* in controlling cost is mixed, working in some places but not in others; its effect on the quality of care is mixed and inconclusive. *Cost-sharing* and *co-payments*, but particularly the latter, do reduce health care demand, particularly with low-income patients. The European countries usually exempt the poor and the old from co-payments, reducing any potential health threats, but in general there seems no good body of evidence (except in developing countries) that co-payments directly harm health.

Private health insurance is mainly a serious problem in developing countries where it can lure the best physicians out of the public sector, reduce the interest of the affluent (small in number) in the public system, and gradually weaken that system. It has not proved a serious problem in universal care countries, in great part no doubt because it remains a comparatively small part of the overall systems. As for the last three categories *–for-profit/non-profit, medical savings accounts, physician incentives*, they display few

striking features, other than one. Medical savings accounts will have the most appeal for the affluent, while the other market practices probably do little good or little harm.

The general picture that emerges seems to make clear that the most common market practices have neither great value nor do great harm in controlling costs or improving quality, though they can have some value –but also, depending upon the context, make things worse. Competition has been used with some minor success in the European health care systems but nowhere in a striking way. Co-payments are the only market practices that are used everywhere. Their ubiquity suggests some consensus on their value, at least for controlling costs.

Market Strategies

By market strategy I refer to the place of market practices in health care systems as a whole and, in particular, the mix of government and market practices in such systems. The basic question is this: which kind of health care systems, market- or government-oriented, provide the best health care for their citizens? Some pertinent standards of judgment are costs, health outcomes, patient satisfaction, and quality. The conclusion I draw from my research is that it is almost a «no contest» competition. By just about every meaningful standard, the European universal health care systems are superior –and, within the European systems, the Social Health Insurance systems are slightly superior to the tax-based systems.

Now it is surely the case that superb medical care can be found in the United States and that those fortunate enough (as I am) to have a good employer provider health care plan are as well off as anyone in the world. But our health care costs are much higher than any other country, a large and growing proportion of people have no health insurance and, by standards of outcome and quality, the U.S. ranks well below most European countries. The Canadian system is not quite as good as the best European systems because of its high costs (second only to the U.S.), it serious waiting list problems, and its poor pharmaceutical coverage. Even so, it is superior to the U.S.

Let me briefly summarize some of the available data. The United States ranks 1st on per capita health care spending;13th among developed countries in life expectancy; many other countries perform better by some standard quality indicators; more Americans believe their system needs a complete rebuilding than citizens of Australia, Canada, New Zealand, and the United Kingdom; and the U.S. ranks 17th in its citizens' judgment of its healthcare. Canada and European countries are commonly derided for waiting lists, surely a problem, but they exist in the United States as well, and not all European countries have a serious problem, and at least five have no waiting lists.

How Do They Do It?

The key to the relative success of the European systems is evident enough: considerable government control and regulation. Physician and other health worker salaries are typically negotiated with the government and are lower than in the U.S. Hospital and clinic charges are no less negotiated, the number of hospital beds controlled, and pharmaceutical prices are usually capped (and, as a result, are considerably lower than in the U.S.). Technological innovations are slower to be accepted, often softly rationed in their use, and their distribution carefully regulated. I have been struck many times by a considerably less driven and enthusiastic drive for improved health and medical technology in Europe, and less media attention devoted to it.

The fact that no European country allows direct-to-consumer advertising as does the U.S., nor does Canada, says much about the difference national attitudes toward the instrument and drug industries. Health care is considered an integral part of European welfare states, and one reason for better health outcomes in Europe is that their welfare systems provide a more solid and capacious safety net, with significantly lower poverty rates –all of which is conducive to good public health. American attitudes toward government-provided health care and welfare have historically been, and remain, differ-

ent: hostility to government control and regulation, choice taken to be more important than equity, a love of the market and a rejection of price controls (which is just the beginning of a much longer list of differences).

A note of sobriety is now in order. For all of their past success and continuing good outcomes, the European systems have entered a time of trouble. High unemployment rates, a loss of economic competitiveness, a resistance to still higher taxes, and pressures from a younger generation for more choice and private care, are making market practices more attractive. When European countries find themselves in economic trouble with their health care systems, the only escape valve appears to be an increased market role. That was true in the mid-nineties, during another economic downturn, and is true once again. As noted above, this response is exactly the opposite of that in the United States, where government is more commonly expected to save the economic day. The United States has for years been scratching with its fingernails to move up the mountain to universal care. The Europeans are using their fingernails to hold on to it.

Infinite Technological Innovation

The main force pushing up health care costs in the United States and most developed countries is either new technologies or the intensified use of older ones. The best estimate is that 40%-50% of cost escalation in the United States can be traced to them. No comparable figures are available from Europe but there is every likelihood they would be similar or slightly lower. Technological innovations come from research and, while the National Institutes of Health finances much of the American basic research (and thus of the world in great part), the «translation» of that research into clinical application comes from the private, market sector. While there is no doubt gratification in that sector when health-promoting drugs or devices are developed, it is profit and shareholder satisfaction that is the driving force.

The progress being pursued at both the research and clinical level is what I call «infinity» research: the pursuit of more progress and more innovation with no finite, much less, final goals in mind: simply MORE. By virtue of the underlying market drive, its values are utterly relativistic: the market, if left uncontrolled, will develop whatever will satisfy customer preferences and be bought by them. The market, as a set of impersonal techniques aimed at influencing behavior, has no interest in equitable distribution of what it develops; that is someone else's problem, health care systems. The drug companies have only in a lukewarm way pursued the eradication of tropical diseases for one reason only: there are many potential patients but few good commercial prospects.

In considering the market, then, account must be taken of its central place in raising costs, in its unaccountability to few values other than shareholder satisfaction, its bias toward the satisfaction of individual preferences, whatever they may be, and in its attraction to choice as the highest moral value in health care.

At the basis of European and Canadian health care is not a proclaimed individual right to health care (though such language is sometime heard), but that of communal solidarity. That notion assumes human interdependence, mutual suffering and threat of illness and death, and the vital role of government in promoting good health care.

By its historical dedication to market theory and practice (not wholly, but heavily), and its individualism, the U.S. has historically made it difficult to enact universal care legislation and has encouraged, through the market, the satisfaction of personal, not community goals. An embrace of the market has no less thwarted any serious attempt to even ask, as a public question, what should count as appropriate, affordable, and economically sustainable medical and health system goals? As a set of impersonal strategies to manage behavior, the market can not, of its nature, ask such questions, much less answer them.

There is a way to soften the harsh light I have thrown on the market. One can return to Adam Smith to recall the high place he gave virtues instilled by markets: self-discipline, restraint, and prudence, among others, and no doubt such virtues are helpful in health care. One can also recall the empiri-

cal work of the instrumentalist economists, showing that the market can, under the right circumstances, foster useful competition and increase efficiency. Nor of course is choice something wrong in itself. Most people want a choice about their physician, some say in the kind of health care they receive; and doctors no less want a considerable degree of choice in the way they medically treat their patients. It is, therefore, hardly out of place to consider possible roles for the market –though it is possible that universal care systems can embody the same values, even if in different ways.

But because of its inability to embody a substantive view of the human good (other than choice and personal preference), or of health, any use of the market must, I believe, be subordinated to universal care systems. It can be used to serve them when possible, but never abandoning the value of solidarity that marks their best practice. Left uncontrolled and unregulated, or allowed to become dominant, the market can be, and often has been, the enemy of solidarity, our human interdependence, and thus indirectly of health as well.

There seems little doubt that, for societies as a whole, the market promotes prosperity, fosters independence and entrepreneurship, and can reinforce democracy. But it is fallacy to conclude that, because the market in general is a beneficent force for societal good, it is therefore equally valid in organizing and running health care systems. I call that the «market fallacy.» And I emphasize the word «systems» to distinguish the use of individual market practices as part of overall systems rather than their dominating feature. There is no evidence anywhere in the world to draw such a conclusion about their system-wide value.

The market rewards strong, knowledgeable individuals, and tolerates the failure of entrepreneurs and commercial enterprises (and the success of others) as a sign of the potency of competition. But the world of the sick is marked by a loss of strength and independence, by a diminishment of self-management, by a painful dependence upon others. Providing the economic and social goods to well manage that combination of human vulnerabilities has not been a mark of the market anywhere, nor is there any reason to suppose they could or would.

Declining Birthrates and Aging Societies

Introduction

Let me begin by describing how l got interested in the topic of declining birthrates and aging societies. In 1969, as I was organizing the Hastings Center –a research center focused on ethical issues of medicine and biologhy– I was invited to spend a year at The Population Council working on the ethical problems in trying to lower the high birthrates of that era. The Council was one of the world's leading research center on population and family planning. Its main focus was on high birthrates in developing countries but there were also, at that time, many who worried about them in developed countries.

My job was to determine what means of lowering birthrates would be ethically acceptable. But one day a question came into my head**:** what would happen if birthrates became too low? I put that question to the President of the Council, a distinguished social scientist, Bernard Berelson. He was the one who had the idea of inviting me to work at the Council, a most unusual and innovative idea in those days, when bioethics hardly existed. He simply waved his arms and said he had no time to think about birthrates that might be too low. That was little more than a strange, speculative possibility.

After working on population issues for another decade or so, particularly for the United Nations Fund for Population Activities, I moved on to other issues, and particularly to the problems of aging societies. But I gave no thought at all to the connection between aging societies and birthrates. That connection never occurred to me. Then, about two years ago, I began noticing articles and books on the declining birthrates in Europe and how that decline would increase the number and proportion of the elderly in a society, exacerbating social security and health care for the old. In short, my old interest in population and my more recent interesting in aging had come together.

There was another reason as well for my interest in birthrates. My wife and I have six children, and many people over the years have commented to us that it must have been our Catholic background that explained our behavior. But it was not that simple. My father's Catholic family consisted of 11 children, nine of whom married –but had only 7 children in all. It turned out they had married during our great depression of the1930s. The generation before them had very large families, 6-10 children, but my father's generation did not. How they did it is, to this day, unknown. It was not a topic that children interrogated their parents about in those days –though even as a child I noticed that my parents had separate bedrooms. It never occurred to me to ask why.

My wife and I, by contrast, married in 1954, a time of great prosperity and very high birthrates. It was the era of what are now called the baby boomers, children born between 1947 and 1964. It also turned out that my wife, who was born in 1933, was part of a group of women that year who had an average of 3.8 children for that year, the largest in the 20th century. After the baby boom childbearing era passed –in the mid-1960s– birthrates started to decline again. Four of our six children are married, but they have only had a total of 5 children among them. They loved being part of a large family, but have shown no interest at all in having one of their own. Nor do any of their friends.

The problem of declining birthrates and aging Societies may be understood as two separate issues or one combined issue. While there are different policy needs and approaches for each of them, in the long run, they should be understood as intimately related.

- Low birthrates in a country will increase the number and proportion of the elderly, and in the process will change what is called the dependency ratio, with a smaller number of young people to support a growing number of old people.
- The growing proportion of elderly in a society will mean a decline in the proportion of young people of procreative age, and more resources going to old rather than young, making life for the younger harder. In Spain, as in other countries, there is a gradual increase in support of the old and a relative decline in support of children. There is a vicious circle in declining birthrates –declining birthrates lead to even more of a decline: there will be fewer women to have children.

Historical Background

Let me say something about the historical background of these developments.

Beginning in approximately 1900 birthrates in developed countries, with an average of 6-8 children per woman, began to decline –and they did so well before the advent of modern contraception and legal abortion. This trend was called the «first demographic transition.» By 1970s, most developed countries had reached the steady-state replacement level, which requires an average of 2.1 children per woman.

Meanwhile, though not the story I will tell here, birth rates in developing countries were dropping as well, in part because of a strong international movement to introduce family planning and population limitation programs, many of them initiated by the Population Council. By the 1980s, the international interest in limiting birthrates shifted to a focus on the education and welfare of women rather than family planning programs as a more likely way to influence birthrates. Birthrates everywhere tend to decline as the education for women increases, and that has happened in poor as well as affluent countries. Birthrates in developing countries have for the most part fallen from 7-8 children per woman to 3-4, a remarkable change, and it seems still underway.

Beginning in 1970s, what is called the «second demographic transition» began to occur, that of a decline in birthrates below the replacement level, with a range of 1.9 in France (now increased to 2.1), 1.5 in Sweden, and 1.2-1.4 in a number of southern European countries. Together with Japan, the world's lowest birthrates are found in Italy, Greece, and Portugal, and Spain.

Why 1970? My guess is that the 1960s and 1970s showed a great rise in number of working women, the liberalization of laws and practices on abortion and contraception, and rapidly increasing affluence and standards of living. As with the improvement of education for women, birthrates also decline with a rise in affluence. No one of those variables explains the change; it was, it appears, all of them together. It is a demographic but also a cultural and economic transition. But keep in mind that this development was a continuation of the first demographic transition, which had begun earlier. Except for the upsurge of births in the 1940s, 50s, and early 60s, the trend since 1900 had everywhere been downward. Few observers even in the 1960s, however, foresaw the second transition, continuing downward beyond the 2.1 replacement rate for a steady-state population growth.

Childearing and Aging: Defining the Issues

The main issues of childbearing and Aging are, I believe, religious, cultural, and economic.

For most of earlier human history, the family was the main provider of security and survival. Children were necessary for the economy of the family and, with high child mortality rates, it was necessary to procreate many children in order that a few of them would survive; and there was no way to control the number of children aside from usually dangerous methods of contraception and abortion. Children were also understood to be responsible for the care of the elderly, who could not look to any other source of care. In short, in addition to the absence of effective means of limiting procreation, there was every social and incentive to have children; and, save for high maternal mortality rates, few incentives to limit their number.

It took massive changes on many fronts –better health for babies and mothers, improved education for women and the opening of job opportunities as well, an extended period of young adulthood, delaying procreation, and the emergence of a culture that made marriage and childbearing just one more option in living a life, and one that many young people do not choose.

The issues are religious because the western religions he always given a high place to marriage, the bearing of children, and to the responsibility of the young to care for the old. What are we to make of that tradition? Had religion –and I have in mind here mainly Christianty– simply become fatalistic because, in earlier and primarily agricultural times, there was really no other option for young people. One thing, I believe, is clear: the Church has not

well adapted to these changing views of procreation and marriage, usually treated as moral decline and not, as I believe, a function of a variety of social and economic changes, only part of which reflects a decline in the influence of the Church and traditional moral values (though there is surely some of that).

The issues are cultural because different developed countries have different attitudes toward the comparative roles of the family, of women (and particularly working women), and the state in support of families and aging. Northern European countries, with strong welfare state values, reflect a bias toward government support of families and procreation, while the southern countries have looked toward the family to take care of welfare needs, including the care of children.

The issues are economic because of strong evidence that the economics of family formation and childbearing, as well as policies concerning the elderly, are powerful forces in shaping social policy and cultural values. It is now well understood (or at least believed) by those young people of procreative age that raising a child is much more costly than it was for their parent's much less grandparents generation. They need more education, unemployment is a threat and jobs, even once had, can be precarious; life-time work for one company has all but disappeared. As a result, children hang on to their parents longer –they are harder to get out of the house– and those children are more nervous about their future economic prospects even when that happens.

Bearing a child is always, even for the confident and well off, a gamble. Our President John F. Kennedy once said that «children are a hostage to fortune» Many young people, adding up the benefits and the burdens, are by intimidated by the burdens and more weakly attracted by the benefits. So, they delay procreation until their late 20s and 30s. Yet however many children they have –often only one and less frequently two– public opinion surveys invariably show that they would, if the could, have more. But as any parent knows it is a big jump from one child to two and a real leap from two to three. When I tell young people I have six, an unimaginably high number, they look at me as if I had just arrived from Mars.

While I have come to think that economic forces and conditions are the most important variables affecting the bearing of children, there seems little doubt that they are enhanced by the rise of urban societies and modern industrial life, supplanting the earlier agricultural societies: by the necessity of much more education than was once necessary: by the changing role of women, and by shifting values about the living of a life. Recall that it was Catholicism, with its support of the celibate life of priests and nuns, that was the pioneer of living a life that was not centered on procreation and the family. Many modern people no longer place family life at the top of their list as the most important social institution.

Some Spanish Data

It is Spain so much as Spain offers a very good case study of low birthrates; and I have come to think that what will work to raise birthrates in one country will probably work well in others –assuming there is a political will to do so. While of course Spain has its own general cultural and political values, as well as important regional differences, it shares with other southern European countries some common and decisive values leading to low birthrates. The most important cultural value has, I believe, been a continuing reliance on the family, not on government, to provide economic and social support of family life, a development in contrast to northern European countries that have given government a strong role in supporting welfare. The most important political factor has been weak policies for the support of working mothers, most noticeable when, beginning in the 1970s, the number and proportion of working mothers was rapidly increasing and birthrates had just begun to rapidly decline. That was an important omission because, as birthrates decline so also do the number of women who could, in the future, have become mothers.

At the same time, again in common with other southern European countries, retirement and pension policies for the elderly became increasingly generous, with a low retirement age and close to 100% of economic support after retirement, the most generous in Europe. Here is some important information.

- The Spanish fertility rate is 1.2 (2.1 necessary for population replacement.
- Mean age at marriage is 27, and at first birth is 29, a considerable increase over the past 30 years.
- The unemployment rate is about 10%.
- Over 50% of women work full time, and that number is increasing.
- The 2nd demographic transition in Spain: a radical reduction in 3rd and subsequent children, and a great reduction in 2nd children.
- High unemployment rate for those under 30.
- Tendency of young people to continue to live with parents, often into their late 20s.
- Lower rates of cohabitation and non-marital childbearing than northern Europe –a higher birthrate in Sweden than in Spain is partly attributable to the greater acceptance of children born to unmarried women or born in situations of cohabitation.
- But for immigration, birthrates would be still lower.
- In the year 2020, the population of those under 15 is projected to be half of what it was in 1970, but the percentage of those over 65 will be double what it was 50 years ago –moreover, the small projected percentage of childbearing women in 2020 has potential to lead to even lower birthrates, even as the number of elderly continue to rise.

Reasons for Low Birthrate

Economic/Cultural/Religious–Note easy to Tease Out Their Different Impacts

- High unemployment rates and high housing costs: difficult to afford marriage and childbearing.
- Shortage of part-time work in Spain for young and for working mothers.
- Lack of good economic support for working mothers and for child care.
- Better educational and career opportunities for mothers, and that almost everywhere leads to fewer children.
- Women forced to choose between full-time work and having children.
- Reform efforts at regional level inconsistent.
- Reaction against conservative church and earlier conservative political regimes, which aimed to keep women at home and in childbearing role.
- Franco and Hitler were great supporters of increased birthrates, but mainly for nationalistic and military purposes.
- Availability of abortion and contraception.
- Rising divorce rates.

In sum, it is a variety of factors working together that create the problem. In my view, the economic forces are the most important but are reinforced by the cultural values. Spain seems to me to combine both liberal and conservative values. Taken together, they have not been conducive to childbearing: the liberal values of modern society favor small families and working women, as well as resistance to religious influences; the conservative values of Spanish culture, looking to family rather than government for support of marriage and childbearing, work against childbearing also.

Necessary Reforms

Spanish needs are common to all developed countries;

Childbearing

Every society needs a steady inflow of young people, for intellectual, social and economic vitality –and to provide economic and social support for the elderly. Economists have long pointed out the importance of young people in order to have an energetic and economically productive society. A country with a rising average age of a population approaching age 50 will almost certainly lack the number of young necessary for vitality. Other points to consider are the following:

- Family and childrearing require support from government –family dependence is no longer adequate.
- Educated women need policies designed to make work and childbearing possible; modern women are more likely to give up child bearing than give up work and many women must, for economic reasons, enter the workplace.
- Cultural support necessary for family values but those values must now be set within the context of modern industrial societies, which offer few natural incentives to have children:
  - Children seem to many young people a great deal of trouble, much more so than my generation.
  - Affluence itself leads to smaller families.
- Religious support necessary for pertinent social and welfare values. Not enough to romanticize the family and to oppose abortion and contraception; they are only a small part of the problem:
  - Abortion and cotraception provide means of limiting children but are not, by themselves, the cause of low birthrates
  - The ultimate reason why young people do not have children is that it is difficult, economically and socially, to so. It needs to be made easier.

Support of the Elderly

The growing number and proportion of elderly, exacerbated by low birthrates, Will pose great problems in the future, not only because there will be fewer young people to support them, but because a large and vigorous group of young people are necessary for economic and social strength. What can be done? Even if young people suddenly began having more children, it would take 30 years or more for their impact to be felt; that is, the time necessary for them to enter the work force and become contributing citizens. In the meantime, steps must be taken to deal with the aging problem:

- An increase in immigration: the US does not now have a birthrate problem because of high immigration rates, but this may be changing –but high immigration rates help national birthrates.
- Early retirement policies need to be changed to later ages.
- Efforts need to be made to keep the elderly in the workplace, on either a full or part-time basis.
- There is value in educating the old to take on new jobs and roles.
- Increased effort to induce young people to save for their old age in light of likely need to reduce pension benefits; and they can not depend upon their children for elder care.
- Elderly people should be strong advocates for policy changes supporting childbearing and working women policies.
- Elderly will have to depend more on each other to take care of each other. Special housing units for elderly in good health to live together, and to care for each other as they age.

Conclusion: The combination of low birthrates and aging society pose some very difficult problems. They are separate issues in many ways but, ultimately, closely related. There will be an aging problem because of low birthrates, but the care of the present elderly is an immediate need, which a sudden rise in birthrates will not help. The long-term solution is more children,

but the incentives and policies to raise birthrates must be put in place as fast as possible, understanding that there will be a long lag time for the policies to have an effect. Nothing, however, is harder for most societies than to enact policies now that will not have an immediate effect. But the longer one waits, the worse the problem will be.

About the author: *Daniel Callahan*

Daniel Callahan is one of the individuals who has made the greatest contribution to the development and dissemination of bioethics. In 1969, together with Willard Gayling, he founded the Hastings Center, and served as its President until 1996. He continues to serve as the Director of its International Program.

Callahan is a Senior Lecturer at Harvard Medical School and a Senior Fellow at Yale University. He also works with a number of health institutions, including the Institute of Medicine of the National Academy of Science and the Advisory Committee Centers for Disease Control.

Callahan is the author of numerous publications and studies in bioethics, addressing all those issues which impose limits on medical progress, and seeking to ensure that medical practice is both sustainable and fair. In recent years, his research has focused on health policies with special emphasis on the economic theory of the free market, equality and health costs. His projects investigating medicine and markets examine the impact of globalization on health development in different parts of the world.

His books include:

Taming the Beloved Beast: How Medical Technology Costs Are Destroying Our Health Care System (Princeton University Press, 2009).

Setting Limits: Medical Goals in an Aging Society (Georgetown University Press, 2003).

The Research Imperative: What Price Better Health? (University of California Press, 2003).

False Hopes (Simon & Schuster & Rutgers University Press, 1998).

The Troubled Dream of Life: In Search of a Peaceful Death (Simon & Schuster, 1993).

What Kind of Life: The Limits of Medical Progress (Simon & Schuster, 1990).

* Publications of his which have been issued by the Víctor Grífols i Lucas Foundation include the Spanish version of the Hastings Center document: *The goals of medicine*. The Hastings Center, co-founded by Daniel Callahan, brought together a team of international researchers to consider the goals of medicine as part of an attempt to demystify medicine and enable it to represent progress for humanity as a whole, and to move beyond simply curing disease and extending life expectancy.

Publications

Monographs:

17. *Individual Good and Common Good in Bioethics*
16. *Autonomy and Dependency in Old Age*
15. *Informed consent and cultural diversity*
14. *The issue of patient competence*
13. *Health information and the active participation of users*
12. *The management of nursing care*
11. *Los fines de la medicina (The Goals of Medicine)*
10. *Corresponsabilidad empresarial en el desarrollo sostenible (Corporate responsibility in sustainable development)*
9. *Ethics and sedation at the end of life*
8. *El uso racional de los medicamentos. Aspectos éticos (The rational use of medication: ethical aspects)*
7. *La gestión de los errores médicos (The management of medical errors)*
6. *The Ethics of medical communication*
5. *Problemas prácticos del consentimiento informado (Practical problems of informed consent)*
4. *Predictive medicine and discrimination*
3. *The pharmaceutical industry and medical progress*
2. *Ethical and scientific standards in research*
1. *Freedom and Health*

Reports of the Foundation:

4. *Las prestaciones privadas en las organizaciones sanitarias públicas* (Private services in public health organizations)
3. *Therapeutic Cloning: ethical, legal and scientific perspectives*
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