Aging

By Daniel Callahan

HIGHLIGHTS

- There is a steady rise in world population growth with the fastest proportionate increase coming from the elderly.
- Technological advances in medicine allow the elderly to live longer but with increasingly higher medical costs.
- End-of-life care poses challenges for the doctor-patient relationship and difficult dilemmas for patients and families.
- Many Americans do not have good economic support for their old age.
- In addressing the practical challenges posed by aging, policymakers need to confront serious ethical questions—all old, deep, and perennial.

FRAMING THE ISSUE

The aging of modern societies—a striking fruit of medical advances and improved economic and living standards—is one of the most important global challenges, affecting rich and poor countries alike. Most people in developed countries live long lives and die slowly of chronic diseases. A majority of people in poor countries are catching up in life expectancy and are now also dying from chronic diseases. The U.S. population of those over 65 is projected to rise from 48 million in 2015 to 98 million by 2060. In 2015, for the first time in history, the global population of those over 65 was greater than those under 5.

These changes pose multiple challenges. An aging society brings increased economic pressures to pay for the health and economic needs of the elderly. It changes the ratio of the old to the young and often means proportionately fewer young people to pay for elder family
As people live longer, they also risk financial insecurity. In addition to paying for costly chronic medical care and caregiving, they face the prospect of outliving their savings. Many old people want, or need, to continue working beyond traditional retirement ages, but they may lack the skills to do so in fast-changing societies. Those who do stay in the workforce may block the way of young people seeking jobs.

With more people dying in old age, the very idea of age itself is changing. What ages should now be used for setting policy for Medicare and Social Security? What is a good balance between providing for the health needs of the old and young, particularly when health and social care for the elderly are increasingly costly in comparison with younger age groups? What is a good balance between providing health care and economic security for the elderly?

AGING SOCIETIES: ILLNESS, DYING, AND ECONOMIC SECURITY

The multiple problems of an aging society can be divided into four focal areas, presenting overlapping ethical and policy issues.

Health Care. For all but the poorest countries, health care is costly and a major part of government and private expenditures. Every developed country, regardless of the kind of health care system it has, confronts rising costs. Even countries with guaranteed health care for all find those costs increasingly burdensome. Medical progress, technological innovation, and improved social and economic strength lie behind this development. Taken together, they have led to enormous gains, most evidently in increased life expectancy, lower rates of maternal mortality, decreased infant and childhood deaths, and improved health of all kinds and at all ages.

While it is commonly argued that new technologies will reduce health care costs, that rarely happens; the costs tend to rise. As much as researchers hate to acknowledge it, the cure of one lethal disease will inevitably open the door to another lethal disease. A patient cured of cancer increases his chances of dying from heart disease or dementia, or something else. The highly successful struggle against plagues and infectious diseases has meant that those saved have increased their odds of dying from a chronic illness.

End-of-Life Care. Caring for the dying has a long history in medical care, going back to Hippocrates, through the “art of dying” (Ars moriendi) in the Middle Ages and well into the 19th century. Apart from some relief of pain and crude diagnostic skills, physicians could do little for the dying. By the 1960s, medical progress improved the possibility of keeping critically ill patients alive. This progress created intensified moral dilemmas for physicians and for patients and their families. When and under what circumstances should physicians strive to keep critically ill or dying patients alive? The line between living and dying has become increasingly unclear: there is almost always some technological way to add minutes, hours, or maybe a few days to the life of a dying patient.

Other dilemmas have emerged. When should decision-making power be taken from physicians and given to patients or their surrogates? Views on the answer to that question have shifted significantly over the past 50 years. It began with a movement to eliminate physician paternalism and find ways of balancing doctor-patient roles. In the 1970s, the hospice movement arrived, providing medical and psychological support for dying patients and their families. During this same period a nascent movement began to legalize physician-assisted suicide. (See "Physician-Assisted Death").

Economic and Social Support. While 65 remains a benchmark for retirement, with full Medicare and Social Security benefits beginning then, the age will gradually move up. Many future retirees—particularly the Baby Boomers, now retiring at the rate of 10,000 a day—will face economic troubles because of a failure to save enough money for their old age, and because of shortfalls in their private pensions and income from government programs. Those now in the 46-to-65 age group are projected to be even worse off than older Baby Boomers. Many people living beyond 65 will want, or need, to continue working beyond traditional retirement ages, but they may lack the skills to do so in fast-changing societies. Those who do stay in the workforce may block the way of young people seeking jobs.

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Science and Aging. Scientific and technological advances have helped increase human longevity, eliminated many of the plagues and infectious diseases that once took most people’s lives, allowed us to live long enough to die of a chronic disease (or be cured of it), and improved but also complicated end-of-life care. Underlying those developments, however, is a profound dilemma. Does the scientific
progress that has helped us live longer and better mean that death itself is the ultimate human enemy to be fought against? A number of scientists of a utopian bent, and wealthy entrepreneurs to back them, see no inherent limits to the technological possibilities. Mark Zuckerberg and his physician wife have pledged $3 billion to find a “cure to all diseases” over the lifetime of their children.

Each of the four focal points for aging societies has its own research methods, cadre of specialists and professional journals, and lay constituents and consumers. Yet taken together they overlap and interact with each other directly and indirectly in important ways.

Health care costs influence each of the other areas. They have an impact on the overall economic resources and security of the elderly. Some 18% of Social Security income is spent on shortfalls in Medicare coverage, which nominally covers only 75% of health care costs. Decisions about end-of-life care can be made much more difficult for the critically ill and their families because of costs not covered by their health insurance. These costs are a leading cause of bankruptcy. Most people who are disabled or have chronic diseases such as dementia do not have long-term care insurance coverage. Scientific innovations to extend life expectancies or to medically improve old age are more likely to raise costs, not reduce them.

End-of-life care is complex, usually expensive, and too often troubling and stressful. Good hospice care can relieve many of those burdens for people who are dying, and it continues to grow, now covering some 1.2 million of the 2.6 million people in the U.S. who die annually. But too many patients go into the program much later than is desirable, receiving hospice care for an average of just 17 days. There are several reasons for the delay. In some cases, prognosis is uncertain. Even when it is clear that death is approaching, physicians or families may be slow to accept it. Public opinion polls also reveal fluctuating tension about end-of-life care among both patients and physicians. It might be called the tension between “doing everything” to keep a patient alive and allowing the patient to die. Moreover, families are often ambivalent about what they want. The frequent use—by researchers and the media—of optimistic language such as “promising” to characterize research may also play a role.

The economic and social support of the elderly is influenced not only by government support of the Medicare and Social Security programs, but also by the unpaid support of an estimated 17.7 million family caregivers (see “Family Caregiving”), and an almost countless number of private sector and local civic groups. It is well recognized, moreover, that caretakers can be overwhelmed by their burden of care. That care sometimes lasts for years and is often needed 24/7. For many family caregivers a subtle moral dilemma can present itself if they have to make end-of-life decisions for incompetent family members: they can feel guilty if they approve the cessation of treatment even if it seems the rational and humane thing to do, but they may wonder whether they did so out of self-interest.

An important technological effort is now under way with electronic devices that allow more self-care by the elderly at home. Physicians are able to see a sick person on a screen, the patient can see and talk to the doctor, and diagnostic information can be gained by implanted electronic devices. These devices can reduce the need for caretaker proximity, but they may cause isolation and diminish close human contact. An important question for an aging society is, what are the best ways for technology to contribute to the welfare of the elderly?

ETHICS AND POLICY

How long a life is necessary to be full and satisfactory? Would it help or harm humans to have a significantly longer life span, say to 125 and beyond? How ought we to determine an equitable balance of government support for the young and old? What is a reasonable expectation for family support of the elderly and when ought government to help relieve that burden? Should health care for the elderly ever be rationed, and what would be the criteria for doing so? It has sometime been said that the old and the young have reciprocal obligations to each other: the old should do what they can for the young, and the young should do what they can for the old. Put more pointedly, how much of their own good should each be willing to give up for the good of the other? This question becomes more urgent when the ratio of young to old in a society shifts significantly to more old people.

Most people might agree that these are important ethical questions. Yet it is rare outside of academic circles to find them as part of policy formation and debates on specific policy options. They can seem too large, too daunting, and too “philosophical” to take on. The policy problems are most likely to be addressed as management and organizational challenges, not as ethical dilemmas to be resolved. Better management can help reduce cost escalation. Impersonal cost-benefit analysis can work out the right balance between young and old. More scientific research might cut elder care costs and allow us to live much longer lives—and eliminate the need for rationing. If the market and free choice are given their head, then the philosophical questions can be put aside. Alternatively, more ambitious and better organized government (albeit more costly) programs will do away with the hard moral dilemmas.

In sum, the rationales and conventional policy techniques often evade or obscure the ethical and value issues at stake. Often enough, though, one can detect implicit judgments that reflect the obscured ethical dilemmas and values. Since the days of Socrates, to raise the deepest ethical questions has been to ask for trouble. But, tolerable or not, they are there, usually just below the surface of the policy battles, their presence quietly influential. They can be dodged but it is better to confront them. The more comfortable language of management and organization is necessary—but it is not sufficient.
How can different perspectives be embodied in developing policy? Various American presidential commissions over the years, as well as comparable commissions in other countries, have tried to answer that question. In essence, it is to insure that a variety of academic and professional disciplines are part of the dialogue and process that shapes the policy. Depending on the policy issue, it may be a mix of scientists, philosophers, theologians, or social scientists, and even some non-expert citizens. Each of them is likely to have a different perspective about how the problem at stake should even be understood. And they are likely to disagree with each other. But one way or other, they have to develop a consensus, or even in the end just take a vote. I call this a democratic method and, as is often the case, it can be messy and contentious. And not everyone will be happy with the conclusion. But no better method has ever been discovered.

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