AM I MY PARENTS' KEEPER?

AN ESSAY ON JUSTICE
BETWEEN THE YOUNG AND THE OLD

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Preface

This is an essay about the just distribution of resources between the young and the old. It seeks a principled way, rooted in a theory of justice, to resolve disputes about how income support, health care, and other social resources should be allocated to different age groups in our society. This book is primarily concerned with the just design of social institutions, but it has a bearing on the dilemmas faced by individuals trying to understand what they ought to do for their elderly parents. Although it addresses important issues of public policy and, therefore, is of interest to all those concerned with the well-being of the elderly, current and future, it is a philosophical essay rather than a detailed analysis of policy options.

The central ideas for this book first came to me while I was working on my earlier book, *Just Health Care* (Cambridge University Press, 1985). Health care was of special moral importance, I argued, because it protected equality of opportunity for individuals. An obvious objection to this view was that the "opportunity" of the elderly lay in their past, which implied that there was little reason to provide them with health care. I had to reply to this objection, and thus I was led to think about what age bias in general involved. I came to understand that the age-group problem was a distinct problem of distributive justice, and I tried to articulate its relationship to other work in the theory of justice.

A personal experience involving my aged great-aunt provided me with an important insight into the problem. When my great-aunt became quite frail and suffered some mental impairment, her daughter found it extremely difficult to get adequate home care or an appropriate nursing-home placement. When acute episodes threatened her life, however, she was rushed to intensive care facilities and exhaustive efforts were made to extend her life. In the final of these episodes, I was reassured by her daughter that "the doctors are doing everything to save her." I suggested that perhaps it was time to let her die peacefully, but I was rebuked. "It's my mother—I can't do that." I then asked my cousin whether she would want her daughter to treat her in the same way she was treating her mother. "God forbid," she said, "when my time comes, I just want to go."

I was struck by the contrast between my cousin's view of how she would want to be treated and how she felt compelled to treat her mother. Her own view of how she would want health-care services allocated to her within her own life gave her no guidance in her decisions concerning her mother. Of course, how we would want to be treated is not always a good guide to how we ought to treat others, the Golden Rule notwithstanding. Still, it seemed to me that my cousin's considered preferences about how she wanted to be treated should have more to do with how her mother was treated than the design of our health-care institutions allowed. I began to explore the idea that the socially prudent design of our health-care and income-support institutions should be our guide to what justice requires in the treatment of the elderly. That idea became the central theme of this book.

Though an essay in philosophy, this book is aimed at a diverse audience of nonphilosophers as well. It is relevant to the thinking of sociologists, economists, and gerontologists who have been studying the varied aspects of this "Age of Aging," as Abraham Monk has called it. It provides a unified perspective through which public policy advocates, planners, and administrators can think about proposals for social reform, and it discusses issues of considerable concern to health-care providers concerned with the problems of long-term care or facing attempts to control health-care costs of the elderly. It will be understandable to undergraduates in courses on moral issues, public policy, or aging.

I believe the book will also be of use to the general reader—to anyone who is troubled by the widespread talk of the old and the young competing for scarce resources in our aging society and who wants to

know what ought to be done. When public policies concerning the young and the old are improperly or unjustly designed, it not only hurts each of us during the various stages of our lives, but it also strains our ability to meet our family obligations. I provide motivation for my approach to these problems in Chapters 1 and 2, and I develop its theoretical core in Chapter 3. In Chapters 4, 5, and 6, I apply my Prudential Lifespan Account to health care, first in general, and then to the problems of rationing acute care and providing for long-term care. In Chapter 7, I apply the account to income support and Social Security, and in Chapter 8, I discuss some reform or "half-way" measures. In the Appendix, which will be of particular interest to philosophically inclined readers, I discuss recent criticisms of some central assumptions about the nature of prudence and the moral importance of respecting persons which underlie my approach.

My work on this subject was first encouraged by Daniel Wikler, then (in 1981) Staff Philosopher for the President's Commission for the Study of Ethical Problems in Medicine. He commissioned the paper titled "Am I My Parents' Keeper?," which appeared in several versions and ultimately as Chapter 5 of *Just Health Care*. Since 1983, through generous support from the Retirement Research Foundation, the National Endowment for the Humanities, and Tufts University, I have had extensive time released from teaching to research the material contained here. I could not have written this book, or the papers on which it is based, without this institutional support.

I owe important debts to many individuals as well. I especially want to thank Dan Brock, Joshua Cohen, John Rawls, and Dan Wikler for the many hours they have spent discussing these issues with me when I most needed a critical audience. Dan Brock and Allan Buchanan have generously provided me with detailed written comments on the whole manuscript. The following people have also helped me through discussion or written criticism of my work: Jerry Avorn, Hugo Bedau, Christine Bishop, Margaret Carter, Judith DeCew, Daniel Dennett, Leslie Frances, R. M. Hare, Andrew Reschovsky, Christina Hoff Sommers, Lawrence Stern, and Stephen White. My wife Anne has read various parts of the manuscript and has offered steady encouragement. I especially want to thank Constance Putnam who has provided helpful editorial comments on the whole manuscript.

Some parts of this work draw on previously published papers as follows:

"Family Responsibility Initiatives and Justice Between Age

Groups." *Law, Medicine, and Health Care* 13(4)(September 1985):153–159.

"Why Saying No to Patients in the United States is So Hard: Cost-Containment, Justice, and Provider Autonomy." *New England Journal of Medicine* 314(May 22, 1986):1381–1383.

"Equal Opportunity, Justice, and Health Care for the Elderly: A Prudential Account." In Stuart F. Spicker, Stanley R. Ingman, and Ian R. Lawson (eds.), *Ethical Dimensions of Geriatric Care,* 197–221, Dordrecht: Reidel Publishing Co., 1987.

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Am I My Parents' Keeper?

1

Conflict Between the Old and the Young

Problems of an Aging Society

We bathe in the Fountain of Old Age, even as we continue to search for the Fountain of Youth. Never before has there been such a high percentage of people over age 65, 75, or 85. Indeed, those over 75 and 85 are the fastest growing age groups in the country. Never before have so many adults planned for an old age they will actually live to experience. This aging of society is not just an artifact of the baby boom and baby bust of recent years, though these have their impact. Major, long-term social investments in public health, improved nutrition, and—with lesser effect—medical services have lowered death rates. More important, complex socioeconomic forces have drastically reduced birthrates in industrialized societies through most of this century. In fact, the United States is behind some European countries, where the aging of society is more pronounced. The Fountain of Old Age is fed by deep springs not likely to run dry soon.

The aging of society forces major changes in the institutions responsible for social well-being. As the "age profile" of a society—the proportion of the population in each age group—changes, social needs change.[1] As society ages, proportionally fewer children need education,

1. See Russell (1982) for a detailed study of the effects of the baby boom generation as

fewer young adults need job training, but more elderly need health care and income support. Changing needs find political expression. Strong voices press for reforms of the institutions which meet these needs. At the same time, advocates for existing institutions and their beneficiaries resist change. The result is a heightened sense that the old and the young are in conflict.

Specifically, there is a growing perception that the old and the young are locked in fierce competition for a critical but scarce resource, public funds for human services. The scarcity of these funds, largely the result of recent political trends, only sharpens the competition. In this context many who complain that the old are benefiting at the direct expense of children, the poor, or younger workers are crying "foul." They rally around a call for "generational equity." Indeed, there is now a Washington lobby called Americans for Generational Equity (AGE).

The Old Versus Children and Other Groups

Perhaps the most plaintive cries are about competition between the elderly and children, between grandparents and great-grandparents and their grandchildren. Since 1970, for example, a significant expansion of Social Security benefits has reduced poverty among the elderly—from double the national incidence to a level slightly below the average rate of poverty. In contrast, programs aimed at poor children, such as Aid to Families with Dependent Children (AFDC) have been cut back dramatically, especially since 1980, and many fewer poor children are elegible for help.[2] There are now proportionally more poor children than poor elderly, whereas fifteen years ago these ratios were reversed.[3]

Children who lose entitlements to AFDC lose more than income support for their families, since eligibility for other programs is affected as well. For example, children are losing in head-on competition with the elderly for Medicaid funds. They are now receiving a smaller pro-

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this demographic bulge has passed through schools, entered the work force, and faces retirement.

2. Preston (1984:437) cites a Children's Defense Fund (1984a) calculation that in 1979 there were 72 children in AFDC programs for every 100 children in poverty, but there were only 52 per 100 in 1982. Preston cites Danziger and Gottschalk (1983:746) for their calculation that 56 percent of the elderly would have been in poverty in 1978 had it not been for Social Security income transfers.

3. The "incidence of poverty among children under 14 in 1982 is 56% greater than among the elderly, whereas in 1970 it was 37% less" (Preston 1984:436).

portion of Medicaid dollars than in earlier years, despite an increase in the number of children eligible.[4] This competition may be showing up in mortality statistics. Cutbacks in federal and state support for prenatal maternal care programs have been linked to some increases in infant mortality rates (Knox 1984), whereas increased life expectancy for the elderly coincides with heavy investments in Medicare.

If we look at aggregate measures of the competition between the old and children for all federal funds, we get a similar picture. In 1971, we spent less on the elderly than on national defense, but in 1983 we spent more, totaling $217 billion or $7,700 per elderly person.[5] In contrast, expenditures for all child-oriented programs—AFDC, Head Start, food stamps, child nutrition, child health, and all federal aid to education—totaled about $36 billion in 1984, about one-sixth of federal expenditures on the elderly. Federal per capita expenditures on children are only 9 percent of per capita expenditures on the elderly.[6]

In this competition there are not necessarily any bad guys. The elderly and their advocates are not villians, and their motives are no less pure than the motives of those who speak up for children. Still, in this sharp competition between grandparents and grandchildren, the children, at least the poor ones, are definitely losing.

The competition between the old and children for federal funds is sometimes seen as part of a larger competition, between the old and the poor. One advocate of "generational equity" complained that we spend four and a half times as much on the federal government's retirement programs, including Medicare, which benefit rich and poor alike, than we do on all welfare programs aimed specifically at the poor. We cannot help the poor, so the argument goes, if, as in 1985, about 28 percent of all federal spending goes to 11 percent of the population that is 65 and older—regardless of whether it is rich or poor.[7]

4. Preston (1984:437) cites a Children's Defense Fund (1984a) calculation that "Children's share of Medicaid payments dropped from 14.9 percent in 1979 to 11.9 percent in 1982 despite a rise in the child proportion among the eligible."

5. Preston (1984:438) cites the U.S. Bureau of the Census (1983a:343) for these figures.

6. Preston (1984:438) cites the Children's Defense Fund (1984b, Appendices) for these figures. It should be emphasized that federal figures for spending exaggerate the "bias" (if that is what it is) toward the elderly because they do not include the bulk of educational expenditures, which are financed at the state and local level.

7. See Longman (1985:73) for a clear statement of the complaint that this spending pattern involves generational inequity.

Another group widely portrayed as losing out to the elderly is the working-age population. Those who rally around the call for "generational equity" complain that the elderly are reaping "windfall profits" from Social Security and Medicare programs. For example, they typically collect benefits costing over three times as much as the taxes they contributed to these schemes. Of course, the working-age population benefits from some of these transfers to the elderly—they might otherwise have to contribute more private support to elderly parents. And the working-age population may think that they will receive generous benefits in the future, when retirment comes. But as Longman (1985:73), who is associated with the Washington lobby, Americans for Generational Equity (AGE), urges, "There may be a point at which the young say 'enough' and rise up in revolt against their elders." His point is that the 75 million members of the baby boom generation will not be able to spread the burden of their retirement over as large a group of workers as the current elderly now do. Each retiree is now supported by 3.4 workers, but when the baby boom retires, only two workers will contribute for each retiree.

The threat is to the long-term solvency of the Social Security and Medicare systems. One way to produce solvency would be to stimulate robust economic growth, but such growth would require extensive investment to promote capital formation and to enhance the productivity of the young. Such investment is impossible, AGE complains, when we invest so heavily in consumption by the elderly (Longman 1985:81). Other proponents of "generational equity" advocate a different strategy. They urge "privatizing" our system of income support for retirement by shifting workers away from the Social Security system and into individual or private retirement schemes which are based on vested assets, not transfers from the young to the old. In this way, each cohort will depend on its own resources and be responsible only for its own well-being.

Elderly Parents Versus Adult Children

The conflict between the elderly and other age groups over public money sometimes penetrates right to the level of the family. Currently, families provide about 80 percent of all home health care to the partially disabled elderly. A large number of people need such help. Some 3

percent of the noninstitutionalized elderly are bedfast and an additional 7 percent are homebound (Shanas 1979, cited in Frankfather et al. 1981:6). This care is costly to adult children and other family members, in terms of money, expended time, and the stress of sustaining care over extended periods. As one daughter put it,

> We put her in the shower and brush her teeth . . . . We put lipstick on her and put her hair in a French twist with floral combs . . . . When we go away overnight, we take her with us . . . . I put paper on the floor 'cause she doesn't always make it to the bathroom . . . . I'll paint her apartment, change the light bulbs, and wash the windows. (Frankfather et al. 1981:1)

Despite the high level of care provided by families, rising public expenditures on long-term care have led some legislators in the early 1980s to propose "family responsibility initiatives" in about half the states. If passed, such laws would hold family members legally responsible for costs currently paid by Medicaid. The effort is to shift costs out of public budgets, where financial responsibility is spread over the tax base for the program, and onto individual families wherever possible. Even if the overall costs of care for the elderly are not reduced through such initiatives, since individual families will still pick up the tab, the burden of bearing those costs will fall much more heavily on a narrower group of the young, those with frail elderly parents. For them, the burden of caring for elderly parents will intensify. Adult children will find that resources they need for their own impending retirement, or that they might spend on their own children's or grandchildren's education, will have to be spent on care for their own aged parents. Shifting costs out of public budgets, however, will not eliminate competition between the elderly and the young for resources. It will only shift the locus and burden of that competition—from public budgets to family budgets. Thus a public decision not to treat the provision of long-term care as a social obligation would only intensify conflict within families.

Unmet Needs of the Elderly

There is, of course, another side to the competition between the old and the young. Though we spend heavily to meet the needs of the elderly—and we have just seen arguments suggesting we spend too heavily—

their needs are far from met by existing institutions. Perhaps the clearest example of the failure to meet important needs is our long-term care system—the nursing homes, personal and home care services, and mechanisms for financing them. Of course, the long-term care system treats the young as well as the old, and by no means do all the elderly use it. It is important to remember that the elderly are heterogeneous, with regard to both family situation and health status. Relatively few elderly in the 65–75 age group suffer disability, but the frequency of disability increases dramatically with advanced age.[8]

The long-term care system is widely criticized for leaving millions of partially disabled elderly unable to sustain their normal lifestyle. People with only mild disabilities, who could maintain normal patterns of living if they had modest help, cannot find or finance the home care and social support services they need. For example, there is no market in which we can buy adequate private insurance for such care, and these services are usually not reimbursable with public money. Ultimately, millions of elderly are forced into premature and inappropriate levels of dependency on their families or institutions. Obviously, this failure poses problems not just for the disabled elderly, but for their families. Families who provide care must do so without the benefit of services, such as day-care or drop-off centers for the elderly, which provide temporary relief from the burdens of care. This is the part of the health-care system which we have left most in individual hands, without benefit of group risk-sharing or social insurance schemes.

Despite these inadequacies in meeting the needs of the elderly, the long-term care system is very expensive. State budgets, which contribute to Medicaid costs for nursing home care, groan with the burden. What is worse, since the most rapidly growing age groups are those over 75 and 85, the groups which need the most long-term care, there is no possibility of meeting future needs at today's levels without proportionally greater budgets for long-term care. It is thus likely that unmet needs will grow significantly.[9]

8. Soldo and Manton (1985), in their excellent study of health needs of the oldest old, report that 6.7 percent of those 65–74 require personal care assistance, 15 percent of those 75–84, and 44 percent of those 85 or over.

9. Some recent changes in the acute care system may exacerbate these problems. Medicare cost-containment measures reimburse hospitals a fixed amount that depends on the diagnostic category for each elderly patient. This gives hospitals strong incentives to release patients earlier than has been customary, but there is a lack of home care for such patients.

Not all health-care needs have been created equal. The vast reservoir of real, unmet needs for long-term care contrasts sharply with the extensive provision of acute-care services. Despite recent cost-containment measures affecting Medicare, we lavish life-extending resources on the dying elderly as if we were meeting their most urgent medical needs, and we point to this glamorous challenge to death as if it proved we value highly every last minute of their lives. And indeed, it is the "last minute" we appear to value most, as that is the one for which we most vigorously provide. But it is far from obvious that prolonging the process of dying in these ways meets an important health-care need. Often, such care merely traps the elderly in treatments they and their families do not want. Even explict preferences the elderly may have to discontinue treatment are frequently ignored. Perhaps even more common is a trap we create out of obligations we feel to do everything possible to "save" our parents or our spouse, even if we would reject such treatments for ourselves had we the choice.

In sum, our health-care system reflects serious confusion about which of the health-care needs of the elderly are most important to meet. It behaves as if the most urgent need of the elderly is to forestall death when it is imminent, whatever the cost. But in the course of doing so we leave unmet urgent needs that plague millions of elderly for long periods of their lives, while they age. Were the system not lubricated by good intentions, it would seem open to the charge that it is biased against the elderly. That is, it appears to be designed to meet the needs of the young, whose profile of needs is quite different. Of course, the system is not lubricated only by good intentions, since it may also serve the interests of the providers of care better than the interests of elderly recipients, and these interests of providers may happen to coincide with the interests of the young.[10]

We have already seen that the proportion of the elderly population in poverty is comparable to that of the population as a whole, not any higher. But this still means that millions of elderly live in poverty, and millions more live near the poverty line. Moreover, the poverty of the elderly is unevenly distributed, for example, by race and sex. The needs of the elderly for income support thus remain substantial. We can reduce expenditures to meet these needs only by vastly increasing the number of elderly people living in poverty—unless we can target our transfers to the poor elderly more effectively, for example, through

10. I am indebted to Allan Buchanan for this point.