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Viewpoint

Rethinking Population Policy: Values, Structural Constraints, and Implications for Health System Sustainability

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Population policy affects people directly, yet the values underpinning these choices are rarely made explicit. Population policy—often framed narrowly around influencing fertility through pronatalist or antinatalist measures—remains deeply contested, reflecting political, social, and ideological priorities[1] about who decides, in whose interests, and at what cost.[2]

In this paper, informed by discussions at the Prince Mahidol Award Conference (PMAC) 2026 Parallel Session (PS) 2.5, "Diverse Values and Ethics in Designing Population Policies," we argue that population policy should be understood as value-responsive, rather than a purely technical exercise, impacting the health and well-being of people. Values differ across settings and are not uniform within societies. They may reflect individual or collective priorities, can come into tension with one another, and are translated differently into policy decisions.[3] When policies privilege some values over others, value-responsive policy-making requires recognising whose values are prioritised, whose are marginalised, and how less-represented values can be meaningfully accommodated and protected in policy design and implementation.

Drawing on policy experiences discussed during PMAC 2026 PS 2.5, we examine these tensions through different ethical perspectives. Utilitarianism emphasises collective welfare, egalitarianism concerns the fair distribution of opportunities and burdens, and communitarianism highlights shared responsibilities and collective well-being. We use these perspectives to examine experiences of population control in India, well-being-oriented development and emigration in Bhutan, and gendered responsibilities for unpaid care in some African contexts. Across these experiences, we identify a recurring concern. When policies prioritise certain values without adequately accommodating others, groups whose values and interests are less well represented may bear disproportionate burdens. This highlights the importance of complementary measures in value-responsive policy-making.

These value-driven policy choices may also influence how the benefits and costs of demographic change are distributed, with implications for health system financing, workforce, service delivery, and leadership and governance of health systems. We examine these potential implications through the World Health Organization (WHO) Health System Building Blocks to consider how population policy choices relate to health system sustainability.

Finally, we propose an initial conceptual framework for future research examining how values and structural factors interact to influence public attitudes towards population policy and how policy responses may have implications for health system sustainability.

Values Shaping Population Policy Vary by Context

India was the first country to launch a national family planning programme in 1952.[4] Historically, population control was prioritised amid concerns that rapid population growth would strain resources and public services and exacerbate poverty and unemployment.[5] During the 1950s-1970s coercive approaches were adopted, particularly during the 1975-1977 Emergency, when mass-sterilisation disproportionately affected poor and marginalised populations amid inadequate consent. Women have also borne a substantial sterilisation-related burdens and risks.[6] During PMAC 2026 PS 2.5, the adoption of two-child policies in some Indian states was highlighted as an example of governance reforms rather than health policies, using incentives and disincentives.[7] Another initiative discussed was the use of "edutainment" (entertainment-education), such as Main Kuch Bhi Kar Sakti Hoon, to address gender inequalities alongside broader population objectives.

These experiences illustrate tensions between collective socioeconomic objectives and individual reproductive justice. From a utilitarian perspective, population control policies may be justified by their anticipated benefits to collective welfare conflict with individual values, particularly when the costs are borne by the disadvantaged populations.[8] These tensions underscore the importance of safeguarding individual rights

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and considering complementary measures to address unequal burdens when pursuing collective policy objectives.

In Bhutan, population policy is framed around collective well-being, compassion, happiness, and equity as its dominant values. Bhutan's Gross National Happiness framework prioritises overall well-being beyond economic growth.[9] However, substantial emigration among young and educated populations, driven by unemployment, inadequate earnings, and limited career progression,[10] suggests that individual economic and career aspirations may not be adequately reflected in current policies. Drawing on egalitarian principles of fair equality of opportunity, this raises questions about whether individuals have equitable access to meaningful opportunities to pursue lives they value.[11] Bhutan has been working to create employment opportunities,[12] and initiatives supporting marginalised populations, including skills development and reintegration programmes for prisoners and youth,[13] were also highlighted. Such responses can be understood as complementary policy measures that address unmet needs to compensate those whose values are not fully covered by the dominant policy, while contributing to broader national well-being objectives.

Ethics and the Hidden Costs of Policy

Even when policies reflect certain values, their implementation may generate insufficiently recognised costs and burdens. Unpaid care work illustrates this tension. Communitarian perspectives emphasise shared responsibilities and collective well-being,[14] particularly within families and communities. However, women bear a disproportionate share of unpaid care work globally, particularly in Northern Africa and Sub-Saharan Africa.[15] During PS 2.5, it was highlighted that a significant share of care is provided through unpaid, household-based work, largely by women, yet remains largely unrecognised in health system performance metrics. From an egalitarian perspective, this raises concerns about gender equity and individual autonomy, as disproportionate care responsibilities may constrain women's opportunities for education, paid employment, and economic independence, particularly where formal care services are limited.

Such responsibilities represent hidden costs borne by households rather than recognised in policy design.[16] When these burdens are shifted rather than reduced, policy may appear efficient while reinforcing persistent inequities. Ethics, therefore, must be understood in terms of how costs, responsibilities, and benefits are distributed across society.

Together, the experiences discussed at PMAC 2026—India's population-policy history, Bhutan's emphasis on well-being and compassion, and the gendered burden of unpaid care in some African contexts—highlight a recurring pattern: policy priorities may not adequately accommodate the values and interests of all population groups. Although these experiences arise from different contexts, they illustrate tensions between collective objectives, individual aspirations, and the unequal distribution of responsibilities and burdens. Our comparison suggests that value-responsive policy-making requires recognizing whose values are prioritised, whose are less represented, and how complementary measures can address their needs and interests.

From Values to Health System Implications

The values embedded in population policy can have consequences that extend beyond demographic outcomes to the implications for organisation and performance of health systems. These implications can be examined through WHO Health System Building Blocks, comprises of service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership and governance. Across the cases discussed here, health workforce, financing, service delivery, and leadership and governance are particularly relevant.

A pronatalist policy may seek to increase the future workforce and tax base, potentially strengthening the economic resources available to finance health systems and contributing to the future health workforce. However, it was highlighted that in many settings, declining fertility and population ageing have prompted such policies to sustain labour markets and pension systems, yet changes in fertility take decades to affect the working-age population, limiting their ability to address immediate workforce pressures.[17,18] Migration can help fill labour gaps more quickly but remains politically constrained in many settings.[19] Population growth may also increase demand for health services and require corresponding investments in service delivery, infrastructure, and financing. Conversely, a utilitarian population-control orientation, as illustrated by India's historical experience, may seek to reduce pressure on resources and public services, including healthcare, but when collective goals are conflicting with individual values, coercive implementation can undermine trust in health institutions and discourage engagement with health services, particularly among affected groups.

In Bhutan, emigration among young and educated populations, may constrain health workforce availability and service delivery capacity. Efforts to expand employment opportunities, develop human capital, and improve public-sector retention therefore represent a complementary policy layer that can also help sustain health system capacity.

Similarly, where care responsibilities fall primarily on families can reduce participation in paid work and limit the pool of workers available for formal healthcare, creating longer-term challenges for workforce capacity and long-term care sustainability as populations age. Strengthening long-term care infrastructure and support services can therefore function as a complementary policy by redistributing care responsibilities beyond households, enabling family members to participate in paid work while maintaining their role in caregiving.

Beyond these building blocks, health system sustainability requires investment in the structural foundations, including social determinant of health that shape both population health and people's capacity to make meaningful choices, including equitable access to education and healthcare. Strengthening these foundations can expand people's capabilities to make reproductive decisions while enabling health systems to respond to changing population needs. The role of the state,

therefore, is not necessarily to determine what is best for individuals, but to create conditions in which people can make meaningful choices.

Towards a Value and Structural Lens for Population Policy and Better Health and Well-Being

The cases above show how values shape the goals and the direction of population policy. However, values and structural factors are interconnected and can influence fertility decisions. Structural factors can create opportunities and constraints for family formation, while shared values and norms influence how individuals interpret these conditions and form fertility intentions.[20] When considered at the population level, these individual decisions contribute to demographic trends that can shape population policy priorities. At the same time, values can guide decision-making, attitudes, and behaviour across different contexts, as conceptualised by Schwartz's Basic Human Values Theory which has also been applied to the study of public policy.[21]

Together, we propose the initial framework (Figure) to be further developed and refined in future empirical work. The framework will examine how values and norms, along with structural factors interact to shape public attitudes towards population policy,[22] influence policy responses, and affect health system sustainability.

Demographic transition provides the broader context for the framework, influencing structural factors and values while also being influenced by structural factors. Structural factors may, in turn, influence the values and norms held by individuals. Values and norms shape public attitudes towards policy responses including fertility support, migration, and long-term care, with structural factors moderating how values translate into attitudes. These attitudes may subsequently influence health system sustainability, particularly across health financing, health workforce, service delivery, and leadership and governance, among the four WHO health system building blocks most relevant to the cases discussed. At the same time, demographic transition may exert direct pressures on health systems. How people experience the health system may also feed back into structural conditions, particularly at the household level.

Key questions remain, including how policy feasibility and accessibility are shaped, and how the values and norms underlying population policy relate to health systems. The relationships between the different boxes and dotted lines indicate relationships that require further empirical testing.

The values included in this proposed mechanism were adapted from Shwartz's theory and a targeted review of selected countries represented in the PMAC 2.5 session, with further consultation with the session co-organisers and speakers. The structural factors were identified through targeted review of relevant literature and policy documents. Given the limited timeframe, these reviews were conducted to provide an initial foundation for discussion during the conference rather than a comprehensive method. We recognise that additional structural factors and values may emerge through empirical research.

Reframing population policy through this lens shifts

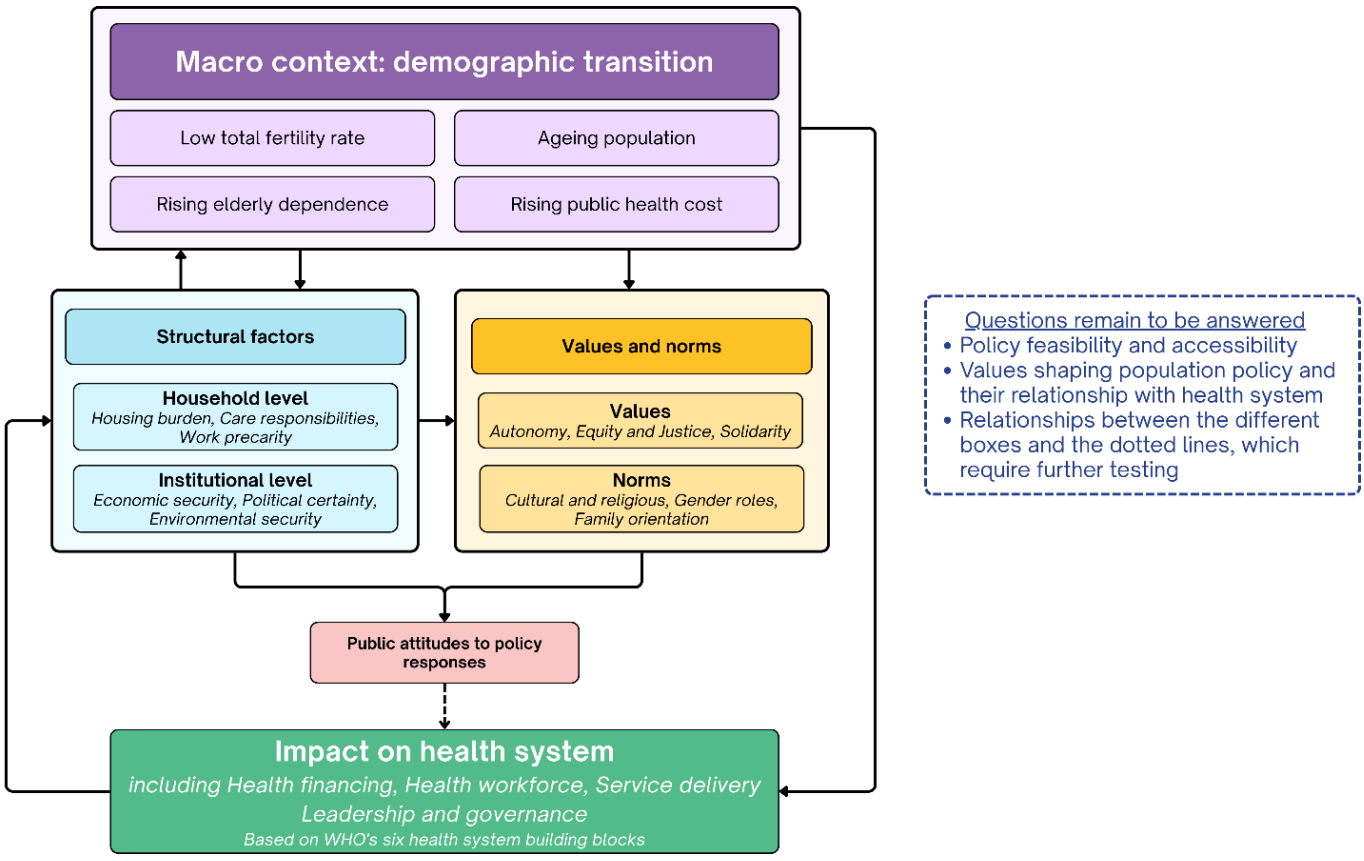


Figure. An Initial Value-Responsive Framework for Population Policy and Health System Sustainability. Abbreviation: WHO, World Health Organization.

attention away from numerical targets toward building equitable, resilient, and responsive systems. These insights are highly relevant for health policy, as demographic change shapes demand for services, the distribution of financing, amount of health workforce, and the performance of health systems. Aligning policy with both values and structural factor is therefore essential for both demographic outcomes and effective health systems. This conceptual framework provides a starting point which remains to be empirically tested for examining these relationships, which we intend to take forward through empirical research.

Conclusion

Demographic change is not a problem to be solved through fertility targets alone, but in how policy responds to it, whose values that response reflects, and who bears its costs. This paper argues that population policy should move beyond fertility targets toward a value-responsive approach that recognises the diversity of values within society and considers how less-represented values can be accommodated or protected. Where policies reflect a dominant value, complementary measures may be needed to mitigate or redistribute the costs borne by those who may be disadvantaged by the policy. Importantly, the implications of population policy extend beyond demographic outcomes to sustainability of health systems. Considering how policy choices affect aspects of health systems is therefore essential to developing population policies that are equitable, responsive, and sustainable.

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Ethical issues

Not applicable. This manuscript is a viewpoint drawing on existing literature and discussions from PMAC 2026. Although anonymous survey and live polling activities were conducted as part of the conference, their findings are not included or analysed in the revised manuscript. The manuscript does not report primary research involving human participants, and ethical approval was therefore not sought for this viewpoint.

Conflicts of interest

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References

1. Joulaei H, Morshed-Behbahani B, Ghadimi P, Nadimi Parashkouhi S, Mansoori Y. Contentious population policy-making and its consequences: a health policy analysis. *Int J Equity Health*. 2025;24(1):96. doi:10.1186/s12939-025-02469-4
2. Yeh MJ, Lee PH. The ethics of population policy for the two worlds of population conditions. *Health Care Anal*. 2024;32(1):1-14. doi:10.1007/s10728-023-00462-y
3. Whyle E, Olivier J. Social values and health systems in health policy and systems research: a mixed-method systematic review and evidence map. *Health Policy Plan*. 2020;35(6):735-751. doi:10.1093/heapol/czaa038
4. Family Planning Association of India (FPA India). FPA India. About Us. https://fpaindia.org/about-us/who-we-are.
5. Nandini Raizada. India's Gigantic Population: Need For A Population Control Law. *Indian Journal of Law and Legal Research*. 2024 Feb 3;5(6). https://www.ijllr.com/post/india-s-gigantic-population-need-for-a-population-control-law.
6. Sam Rowlands, Pramod R. Regmi. The Use of Forced Sterilisation as a Key Component of Population Policy: Comparative Case Studies of China, India, Puerto Rico and Singapore. *Indian Journal of Public Administration*. 2022;68(2):271-284. doi:10.1177/00195561221082984

7. Bilal Kuchay. Why two-child plan in India's most populous state is 'coercive.' *Aljazeera*. July 21, 2021. https://www.aljazeera.com/news/2021/7/16/why-two-child-policy-in-indias-most-populous-state-is-coercive.
8. Blackorby C, Bossert W, Donaldson D. Foreign aid and population policy: some ethical considerations. *Journal of Development Economics*. 1999; 59(2):203-232. doi:10.1016/S0304-3878(99)00010-3
9. Organisation for Economic Co-operation and Development (OECD). Bhutan's Gross National Happiness (GNH) Index. https://www.oecd.org/en/publications/well-being-knowledge-exchange-platform-kep_93d45d63-en/bhutan-s-gross-national-happiness-gnh-index_ff75e0a9-en.html. Published August 23, 2024.
10. Jumana Alaref, Alvin Etang Ndip, Cheku Dorji, Laurine Martinoty. Migration Dynamics in Bhutan: Recent Trends, Drivers, and Implications. Washington, DC: World Bank; 2025. https://documents1.worldbank.org/curated/en/099071025222089550/pdf/P509392-07140ea4-b0fa-489b-a384-7e7494758a5e.pdf.
11. Rawls J. *A Theory of Justice*. Harvard University Press; 1971. doi:10.2307/j.ctvjf9z6v
12. Diana Chung, Mehrin Ahmed Mahbub. World Bank Supports Bhutan's Reform Efforts to Create Jobs. https://www.worldbank.org/en/news/press-release/2026/04/01/world-bank-supports-bhutan-s-reform-efforts-to-create-jobs. Published April 1, 2026.
13. The PEMA. Royal Bhutan Police, The PEMA Secretariat, and Ministry of Agriculture and Livestock sign a Tripartite Agreement to Establish Yarju OAP for Prisoners' Reintegration. https://thepema.gov.bt/royal-bhutan-police-the-pema-secretariat-and-ministry-of-agriculture-and-livestock-sign-a-tripartite-agreement-to-establish-yarju-oap-for-prisoners-reintegration/. Published March 14, 2025.
14. Cordeiro-Rodrigues L, Metz T. Afro-Communitarianism and the Role of Traditional African Healers in the COVID-19 Pandemic. *Public Health Ethics*. 2021;14(1):59-71.
15. Jacques Charmes. The Unpaid Care Work and the Labour Market. An analysis of time use data based on the latest World Compilation of Time-use Surveys. Geneva: International Labour Organization; 2019. https://www.ilo.org/sites/default/files/wcmsp5/groups/public/%40dgreports/%40gender/documents/publication/wcms_732791.pdf.
16. Jones E, Ruiz I, Undurraga S. Repositioning care in economics: concepts, measurement, and policy implications. *Oxf Rev Econ Policy*. 2025;41(3-4):653-675. doi:10.1093/oxrep/grag001
17. Forati R, Bartz D. The rise and fall and rise of pronatalism: a disingenuous policy that harms the health of people and society. *J Law Med Ethics*. 2025;53(3):435-443. doi:10.1017/jme.2025.10129
18. Boydell V, Mori R, Shahrook S, Gietel-Basten S. Low fertility and fertility policies in the Asia-Pacific region. *Glob Health Med*. 2023;5(5):271-277. doi:10.35772/ghm.2023.01058
19. Lorenzo Beadle. Demographic decline and the role of immigration. 2025. https://clubmadrid.org/wp-content/uploads/2025/09/DEMOGRAPHIC-DECLINE-AND-THE-ROLE-OF-IMMIGRATION.pdf.
20. Bachrach CA, Morgan SP. A cognitive-social model of fertility intentions. *Popul Dev Rev*. 2013;39(3):459-485. doi:10.1111/j.1728-4457.2013.00612.x
21. Schwartz SH. An Overview of the Schwartz Theory of Basic Values. *Online Readings in Psychology and Culture*. 2012;2(1). doi:10.9707/2307-0919.1116
22. Vélez CM, Wilson MG, Lavis JN, Abelson J, Florez ID. A framework for explaining the role of values in health policy decision-making in Latin America: a critical interpretive synthesis. *Health Res Policy Syst*. 2020; 18(1):100. doi:10.1186/s12961-020-00584-y