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# The Aged and the Allocation of Health Care Resources

**Pat Milmoie McCarrick**  
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Two different sets of statistics are increasingly linked in the literature about health care resources in the United States: the demographic aging of the American population and the steadily rising cost of health services.

Persons 65 years of age and over made up 9.2% of the population in 1960 and 12.3% in 1990; this figure is projected to increase to 20% by 2020 as the baby boom generation becomes 65 (II, Sonnefeld 1991). Within this group, the percentage of those over 85 years of age (whose average health costs are six times higher than those for someone 65 years of age) will double from 3 million in 1990 to 6.1 million in 2010 (II, Samuelson 1992). The cost of health services in 1990 reached \$661 billion dollars, or 12.6% -of the Gross National Product (GNP). This is “twice the proportion of 1965 and the highest GNP proportion for any developed nation”(III, Rich 1990). If health costs continue to rise at the present rate, health spending could reach 18% by the turn of the century (II, Samuelson 1992).

The enormous expenditures for health care give rise to great concern among those who think that these health resources are finite and that the desire for health benefits is infinite. The development of complex medical technologies in the last 50 years not only saves lives and provides increased longevity, but also greatly increases the cost of treatment.

In 1969 in an essay about kidney dialysis, Paul Ramsey wrote about the moral issues involved when certain treatments are not available to all in need, and decisions are made to choose who shall receive such care. He noted that some in the health professions held that to select patients suitable for treatment based on the patient’s age, family, or potential social worth was not proper; such selections should be random or on a first-come, first-served basis. He discussed the concept of macro-allocation of extremely costly treatments by the government when the need outpaces efforts of the private sector to fulfill it, and pointed out the dilemma if judgment does not know when “increasing the availability of medical care is of a higher priority than replacing slum housing. Moreover, even after it is decided to devote a given percentage of public funds to medical care, it is still necessary to know how much of this money should be spent on very expensive treatments. More lives might be saved through funds

expended on basic research or on preventive medicine or on improving a hospital's general surgical facilities." Ramsey concluded that scarcities in medical resources are not a new development, but that developments in medicine have focused public concern on the allocation of new treatments. He said that money was the "ultimate" scarce resource; therefore allocation would be an ongoing problem with regard to medical treatments (III, Ramsey 1969).

In recent years the rationing of health care and how best to achieve fair, equitable or just distribution of health services has been widely discussed and written about. In the United States rationing is generally not thought to be the way health resources should be meted out to the nation; however, monies from the government are allotted by disease (dialysis) or age (Medicare) or economic need (Medicaid) or race (the Indian Health Service); private contributions or health insurance determine what care is received by others desiring health resources. Eighteen possible ways to ration health care have been suggested: ability to pay, age, residence, entitlement, need, anticipated clinical outcome, political contacts, acceptability as a research subject, lottery, first come first served, social worth, moral or religious worth, public or media pressure, specialty groups' power to command resources, attractiveness to screeners, risk of death or serious illness or injury if treatment is withheld, and finally, risk of legal or financial liability if treatment is withheld (II, Churchill 1988).

The age of the patient has become one of the relevant factors in possible decisions about how health resources could be allocated. Avorn has written, "The elderly population poses the most important questions about resource allocation in the coming decades" (II, Avorn 1984). Richard B. Lamm, former governor of Colorado, was widely quoted as saying that the elderly had a duty to die since their prolonged use of medical resources denied them to the young and future generations (II, Gov. Lamm 1984). Several commentators have suggested different guidelines for achieving a just distribution of health resources between generations. This Scope Note describes some of them. It does not try to discuss the meaning of justice, nor does it include citations to literature about Medicare and Medicaid, the economics of medicine, advance directives, the uninsured, any

general right to health care, or efficient health care delivery. Each of these topics is relevant to the aged and to how health money is spent, but only references concerning allocation with respect to the aged person are included.

Daniel Callahan, director of the Hastings Center, has written many articles about aging and health care. In 1987, the publication of his book, **SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY**, brought his views to a wide public and intensified discussion about possible changes that could be made to achieve better use of resources. He sets forth the idea that each person has a "natural life span" of about 80 or 85 years and that spending a disproportionate amount of money on life extension technologies for those who have reached this age is unwise. He urges the elderly to find meaning and significance in old age by providing the young with a perspective of life as a whole, and not by trying to avoid facing the reality of oldness and the nearness of death which comes to all. He suggests age as a criterion for deciding when to stop medical care and offers specific steps to classify appropriate treatments (I, Callahan 1987)

Norman Daniels, who writes often about justice in health care, suggests a theory he calls the "prudential lifespan account." He says that age is nondiscriminatory, that every person ages, but that not everyone can be in one category of sex or race. If the young or the old are treated differently at different times within their life spans, each person will receive whatever share is given since everyone will be young and be old. He would rely on market mechanisms to allow each person to express prudent preferences in choosing what health care he or she wants at each stage of life. He argues that a rational consumer would want realistic insurance coverage with benefits to fit real needs. Daniels finds rationing by age morally objectionable (I, Daniels 1988).

Robert M. Veatch writes that an obvious place to impose limits for just health care is in treatment for the terminally ill since it is probable that the patient will die relatively soon after being treated. His proposal for limiting care on the basis of age gives persons priority in inverse proportion to their age; older persons have had more opportunity for wellbeing than younger persons. "In a comparison between two critically ill patients, one

an infant and the other elderly, the infant has much stronger claims on resources in order to have an opportunity for wellbeing over its lifetime.” Veatch states that in resource allocation, approaches which take into account either the full lifetime or conversely, only a small part of the life span can be utilized when there is a severe restraint in limiting care for all terminally ill patients. It would be necessary to differentiate between greatest need at a moment in time and greatest need for wellbeing over a lifetime (II, Veatch 1988).

The following selection of books and articles provides a broad view of the discussion surrounding rationing health care resources to the aged population. Some early publications were chosen to provide general background material and to offer an overview to some of the newer work.

## I. Books

Aaron, Henry J., and Schwartz, William B. **THE PAINFUL PRESCRIPTION: RATIONING HOSPITAL CARE.** Washington: The Brookings Institution, 1984. 161 p.

The authors compare British and American health care systems and say that if rationing is inevitable, the U.S. could learn from the English National Health Service. The British limit some expensive technologies to persons under certain ages.

Blank, Robert H. **RATIONING MEDICINE.** New York: Columbia University Press. 1988. 290 p.

An ethic of individual responsibility to lead a healthy personal life style is recommended by the author, who favors an equitable base of primary care for all citizens before any high cost technology is offered.

Binstock, Robert H., and Post, Stephen G., eds. **TOO OLD FOR HEALTH CARE: CONTROVERSIES IN MEDICINE, LAW, ECONOMICS AND ETHICS.** Baltimore: Johns Hopkins University Press, 1991. 209 p.

The nine essays in this collection offer a rejection of proposals that would ration health care for people in old age and include positive suggestions to provide health care for an aging society. The 11 authors hold that it is morally and ethically wrong to “forbid lifesaving care to

older persons or to any group categorically, on the basis of demographic characteristics, rather than case by case, on the basis of the individual’s clinical condition.”

Califano, Joseph A., Jr. **AMERICA’S HEALTH CARE REVOLUTION: WHO LIVES? WHO DIES? WHO PAYS?** New York: Random House, 1987. 241 p.

This former cabinet officer who was in charge of federal health resources, writes that failure to develop a system to control the giant health costs connected with death threatens all, but particularly the elderly. An efficient health care system that would eliminate waste, which he estimates at \$75 billion annually, could provide the time needed to study the perplexing ethical, religious and social issues involved. Califano wants to create a system of dignity, justice, and compassion to assure primacy of person over machinery and technology.

Callahan, Daniel. **SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY.** New York: Touchstone/Simon and Schuster, 1987. 256 p.

Written to stimulate a public discussion of the future of health care for the aged, Callahan’s book proposes a different way of distributing health resources, “using age as a specific criterion for the allocation and limitation of health care.” He envisages that it will take several decades for such change to occur.

Churchill, Larry R. **RATIONING HEALTH CARE IN AMERICA: PERCEPTIONS AND PRINCIPLES OF JUSTICE.** Notre Dame, IN: University of Notre Dame Press, 1987. 180 p.

Churchill writes that the United States is currently rationing health care primarily by price, and secondarily by disease, race and age. He thinks that this rationing scheme has remained unacknowledged because it fits both capitalistic values and a consumer mentality.

Daniels, Norman. **AM I MY PARENTS’ KEEPER? AN ESSAY ON JUSTICE BETWEEN THE YOUNG AND THE OLD.** New York: Oxford University Press, 1988. 194 p.

The author’s theory of personal planning for health care use over an entire lifetime is presented. Daniels gives his reasons for choosing

what he says is the most just way, since allocation is not made between groups but within the life span of each individual.

Daniels, Norman. **JUST HEALTH CARE**. Cambridge: Cambridge University Press, 1985. 245 p.

Daniels' earlier work contains a section in which he first develops his idea of an individual who would save prudently to allocate health resources over a lifetime.

Homer, Paul, and Holstein, Martha, eds. **A GOOD OLD AGE: THE PARADOX OF SETTING LIMITS**. New York: Simon & Schuster/Touchstone, 1990. 319 p.

The 28 essays collected were all published in response to Daniel Callahan's **SETTING LIMITS**. The work has an opening essay and an afterword by Callahan; 31 authors from the fields of medicine, law, public policy, and philosophy comment on his views of setting age limits to apportion health care spending.

Menzel, Paul T. **STRONG MEDICINE: THE ETHICAL RATIONING OF HEALTH CARE**. New York: Oxford University Press, 1990. 234 p.

Menzel argues that rationing decisions can be made in health care if policies represent choices made by patients themselves.

Moody, Harry R. **ETHICS IN AN AGING SOCIETY**. Baltimore: Johns Hopkins University Press, 1992. 288 p.

The author describes his work as a meditation on the ideas of autonomy and justice, noting that it is the "inescapable facts of old age that make these ideals problematic." He disagrees with the idea of age as a framework on which to base allocation of health care, but thinks that prudent principles providing intermediate level services should prevail as opposed to spending vast sums to sustain the debilitated elderly.

Smeeding, Timothy M., ed. **SHOULD HEALTH CARE BE RATIONED BY AGE?** Totowa, NJ: Rowman and Littlefield, 1987. 172 p.

The proceedings of a 1985 conference in Colorado has an introduction by former governor Richard D. Lamm, who deplores debt created for future generations and charges that medical care is often determined by whatever would

succeed in a lawsuit. The book includes discussions about the present health and diseases of the elderly; the cost of health care with consideration of age rationing and just distribution; medical decision making and the quality of life; Britain's health policy; organ transplants and long term care for the elderly; and a summary.

Spicker, Stuart F.; Ingman, Stanley R.; and Lawson, Ian R. **ETHICAL DIMENSIONS OF GERIATRIC CARE: VALUE CONFLICTS FOR THE 21ST CENTURY**. Philosophy and Medicine Series, Vol. 25. Dordrecht, The Netherlands: D. Reidel, 1987. 297 p.

Based on a 1984 meeting held at the University of Connecticut, this compilation includes four major sections: Understanding the biology and epidemiology of aging; Philosophical reflections on medical care provisions for the aging; Self determination in late life dependency (this section contains an essay on the economics of suicide in old age); and Justice in the provision of medical care for the aged. An epilogue discusses the problems of disease, disability, dependency, and dementia.

U.S. Congress. Office of Technology Assessment. **LIFE SUSTAINING TECHNOLOGIES AND THE ELDERLY**. Washington: U.S. Government Printing Office, 1987. 461 p.

The report notes that while data can be unreliable in utilization of life sustaining treatment and while future use cannot be accurately predicted, the aging of the population combined with technology improvements and availability will increase demand.

Veatch, Robert M. **DEATH, DYING, AND THE BIOLOGICAL REVOLUTION: OUR LAST QUEST FOR RESPONSIBILITY**. Revised Edition. New Haven: Yale University Press, 1989. 292 p.

Veatch states that one of the purposes in writing this work was to gain insight into the complex dilemmas posed by the technological and biological revolutions and to question rights and responsibility in the final days of life.

Veatch, Robert M., ed. **LIFE SPAN: VALUES AND LIFE-EXTENDING TECHNOLOGIES**. San Francisco: Harper and Row, 1979. 309 p.

The work provides an early perspective on the

social, political and ethical implications of the increase in life expectancy in this century.

## II. Articles/Chapters

American Geriatrics Society Public Policy Committee. **Equitable Distribution or Limited Medical Resources.** *Journal of the American Geriatrics Society* 37(11): 1063-1064, November 1989.

Noting that “the growing number of older Americans and the greater per capita use of medical resources among them make age an obvious target in contemporary rationing debates”, the Committee does not think that the option is ethically sound. It urges physicians to provide a voice in public policy but says that any rationing decisions should be made by all of society. Inefficient practices should be eliminated before reductions in basic health care benefits can be justified, and services that are supportive, preventive or rehabilitative should be as valued as high technological, hospital-based interventions which the Committee says consume a disproportionate amount of available monies.

Avorn, Jerry. **Benefit and Cost Analysis in Geriatric Care: Turning Age Discrimination into Health Policy.** *New England Journal of Medicine* 310(20): 1294-1301, 17 May 1984.

The author thinks that value assumptions guarantee an anti-geriatric bias, since to be unproductive is not cost beneficial. Such assumptions lead to ideas of diminished value with diminished benefits.

Barondess, Jeremiah A.; Kalb, Paul; Weil, William B.; and Cassel, Christine. **Clinical Decision-Making In Catastrophic Situations: The Relevance of Age.** Report of a conference convened by the American Geriatrics Society, April 17-18, 1987. *Journal of the American Geriatrics Society* 36(10): 919-937, October 1988.

The authors suggest that any rationing should be carried out at a societal or constitutional level, not according to age criteria but according to anticipated life expectancy. They discuss the rights of incompetents and the extension of the rights of competent persons.

Battin, Margaret P. **Age Rationing and the Just**

**Distribution of Health Care: Is There a Duty to Die?** *Ethics* 97(2): 317-340, January 1987.

Battin provides background reference to various cultures' views about refusing treatment, encouraging suicide, or otherwise indicating that there is an obligation for the old to die. She urges the need to reconsider societal priorities and to guarantee that resources will, in fact, be redistributed fairly if changes are made in the delivery of health care.

Bell, Nora K. **What Setting Limits May Mean: A Feminist Critique of Daniel Callahan's SETTING LIMITS.** *Hypatia* 4(2) 168-178, Summer 1989.

Stating that older women are poorer, are more likely to live alone, and have less informal social and personal support than older men, Bell says that this group will make the most demand on health resources. If age is the limiting factor in health care, the limits will affect women more drastically than men. Bell suggests that if old age is devalued by Callahan or men in general, it is because it “is peculiarly the province of women” since more women live into their eighties.

Brock, Dan W. **Justice and the Severely Demented Elderly.** *Journal of Medicine and Philosophy* 13(1): 73-99, February 1988.

According to Brock, the destruction of personal identity in dementia implies that only palliative, not life-sustaining health care should be provided. He goes on to say that in the absence of psychological continuity, physical continuity is not sufficient to establish the patient as a person. Brock recommends simple care measures.

Callahan, Daniel. **Aging and the Ends of Medicine.** *Annals of the New York Academy of Sciences* 530: 125-132, 1988.

In this essay, Callahan says that giving transplants to the elderly has accelerated the most expensive and most demanding form of high technology medicine.

Callahan, Daniel. **Old Age and New Policy.** *Journal of the American Medical Association* 261(6): 905-906, 10 February 1989.

The author thinks that gradually increasing Medicare premiums is not enough to solve the problem of rising costs, and he urges a full

rethinking of the relationship between old age and health care. He suggests shifting entitlement emphasis from acute care to long term care, with limits on high technology and life extending care for the elderly. Case-by-case rationing does not take society as a whole into account.

Cassel, Christine K. **Ethical Issues in the Emergency Care of Elderly Persons: A Framework for Decision Making.** *Mount Sinai Journal of Medicine* 54(1): 9-13, January 1987.

Cassel provides an overview of beneficence, respect for persons, and justice in the allocation of resources, and says there is a need to develop a more complex understanding of life expectancy.

Cassel, Christine K. **Issues of Age and Chronic Care: Another Argument for Health Care Reform.** *Journal of the American Geriatrics Society* 40(4): 404-409, April 1992.

The author says that choosing age as a model for rationing medical resources “may be an attempt to turn the clock backward toward a society in which life expectancy was not so long.” She thinks that the societal effects of a policy that would devalue the elderly by automatic exclusion from life-sustaining medical care could be both profound and subtle. Cassel discusses cost containment, quality of life, and the goals of medicine which she says require fundamental changes in education, research, and health care delivery systems.

Cassel, Christine K. **The Meaning of Health Care in Old Age. In: WHAT DOES IT MEAN TO GROW OLD: REFLECTIONS FROM THE HUMANITIES.** Thomas R. Cole and Sally Gadow, eds. Durham: Duke University Press, 1986, pp. 179-198.

Cassel suggests that citizens might vote on such social choices as allocation of health care resources, since in the best of worlds the meaning of health care to the patient should be the sense of its meaning to the benevolent society.

Childress, James F. **Who Shall Live When Not All Can Live?** *Soundings* 53(4): 339-355, Winter 1970.

Saying that dramatic forms of scarce life saving medical resources such as heart transplants require the examination of moral questions, this

20-year old article by Childress reviews lifeboat ethics (including *US v. Holmes*, 26 Fed. Cas. 360, C.C.E.D., Pa. 1842) and a theory of Edmond Cahn’s (**THE MORAL DECISION**, Bloomington: Indiana University Press, 1955) that when all cannot benefit, none should benefit unless some voluntarily allow it.

Churchill, Larry R. **Should We Ration Health Care By Age?** *Journal of the American Geriatrics Society* 36(7): 644-647, July 1988.

The author proposes that Americans’ ideas of abundance result in a reluctance to think about rationing at all, but that priorities must be set. Churchill states that since health rationing more or less exists now, it should be more just. While he says Callahan’s vision is enlightened, he thinks that the elderly would be foolish to comply unless there was a more just overall health system. He disapproves of many extreme and edge-of-life treatments for the aged and others, saying that over-zealous physicians, over-litigious lawyers, and a public clamoring for longevity constitute a grave hazard to the collective well-being.

Danis, Marion, and Churchill, Larry R. **Autonomy and the Common Weal.** *Hastings Center Report* 21(1): 25-31, January/February 1992.

Noting that medical technology continues to grow along with the chronically ill elderly who might use these developments, Danis and Churchill present a discussion of the patient and the health care providers from the point of view of autonomy combined with a concept of citizenship in the community, a citizen ethic which would emphasize “common purposes and shared vulnerabilities.” They hold that citizens have both rights and protections along with responsibilities.

Evans, J. Grimley. **Aging and Rationing: Physiology Not Age Should Determine Care.** Editorial. *British Medical Journal* 303(6807): 869-870, 12 October 1991.

Saying that many health districts in the United Kingdom manage patients above a certain age (varying from 65 to 85) separately from other adults, Evans thinks that age tells something about a patient, but is itself such a variable that it is an unscientific and inequitable basis for choice of care. He urges that all patients be

assessed and treated on the basis of their physiology.

Evans, Roger W. **Health Care Technology and the Inevitability or Resource Allocation and Rationing Decisions.** Part I. *Journal of the American Medical Association* 249(15): 2047-2053, 15 April 1983. Part II. *Journal of the American Medical Association* 249(16): 2208-2219, 22/29 April 1983.

This early study, financed by the U.S. government's Health Care Financing Administration, begins by pointing out that with an aging population, chronic disease and disability will become common occurrences. Resource allocation will become routine. "As these allocation and rationing exercises are undertaken, a new appreciation of medical ethics will come about, accompanied by a more careful assessment of the nature of death and dying within this society." Part II indicates that allocation of health care resources can be subjected to a formalized set of procedures based on cost effectiveness and cost benefit analysis. People have a responsibility and an obligation to care for themselves to insure good health according to Evans, who thinks that rationing will be the shared responsibility of patients, clinicians, and family. The article offers general guidelines for treatment or non-treatment. Evans concludes that the future is likely to be filled with accounts of (named) persons who have refused treatment, and that when rationing decisions are acknowledged as unescapable, society will be more prepared to deal with the one inevitable event, death.

Freudenheim, Milt. **The Elderly and the Politics of Health Care.** *New York Times*: 5, 22 May 1988.

The article provides statistics about the growth of the elderly in the U.S. population.

Fry, Sara T. **Rationing Health Care to the Elderly: A Challenge to Professional Ethics.** *Nursing Outlook* 36(5): 256, September/October 1988.

Nursing educator Fry points out that a new view of aging and health care goals would mean a change in the content of nursing courses. Instead of focusing on individual good, autonomy and freedom of choice, societal good and the prioritizing of benefits would be emphasized

along with newly articulated theories of compassion and a tolerable death.

Gill, Derek G., and Ingman, Stanley R. **Geriatric Care and Distributive Justice: Problems and Prospects.** *Social Science and Medicine* 23(12): 1205-1215, 1986.

The authors say that the elderly have been over "medicalized" with not enough attention paid to social services.

**Gov. Lamm Asserts Elderly, If Very Ill, Have 'Duty to Die'.** *New York Times*: A16, 29 March 1984.

The New York Times report of the much-quoted Lamm statement made on 27 March 1984 is accompanied by his follow-up statement that he meant careful use of complex medical technology "if patients are suffering beyond the ability for us to help."

Halper, Thomas. **Strength Enough: Thoughts on Age-Based Rationing and Intergenerational Equity in Britain.** *HEC Forum* 3(1): 27-37, 1991.

Using a review of the background of the denial of dialysis to elderly Britons in kidney failure, Halper discusses Daniels' intergenerational equity and Engelhardt's individualistic views of health care allocation. His own view holds that, since democracies do not allow the public to decide issues, only to choose leaders, these policy makers must confront the fact that real sacrifices must be made if treatment patterns are to be expanded.

Harris, John. **Life: Quality, Value and Justice.** *Health Policy* 10(3): 259-266, December 1988.

The author discusses QALYs (Quality Adjusted Life Years), which give a value of one to a year of healthy life and less than one to unhealthy life with the highest number of QALY points offering the most cost effective way to apportion medical care. Harris criticizes the plan as valuing time instead of individual lives and having an unjust, excessively narrow view of quality of life.

Howe, Edmund G. **Ethical Aspects of Geriatric Patients' Rights to Refuse Treatment and to Receive Limited Medical Resources.** *Educational Gerontology* 14(5): 451-463, 1988.

Howe argues that a statistical norm used to

determine policy could discriminate against individual geriatric patients whose values differ from the statistical norms. He notes that the elderly are particularly vulnerable due to decreasing physical strength and increasing medical problems.

Jecker, Nancy S. **Aged-Based Rationing and Women.** *Journal of the American Medical Association* 266(21): 3012-3015, 4 December 1991.

Rationing health care based on age will disproportionately affect women, according to Jecker, since there are more older women than older men. She thinks that gender inequalities are more ethically troubling than the inequalities that might result from age-based rationing.

Jecker, Nancy S. **Disenfranchising the Elderly from Life Extending Medical Care.** *Public Affairs Quarterly* 2(3): 51-68, July 1988.

Jecker disagrees with Callahan's theories set forth in *SETTING LIMITS*, saying that she is skeptical about an ideal old age and death, and that there should be further debate about what constitutes a natural life span; which she thinks is only one consideration. Jecker goes on to state that consensus is not possible in our society and that an indefinite theory of old age health care serves the aged best.

Johnson, Paul R. **Allocation and Aging-A Review and Response to Callahan's SETTING LIMITS.** *Linacre Quarterly* 55(4): 57-63, November 1988.

Johnson points out that the aging of the baby boom generation is the cause of the growing political attention to services and care for the elderly. Noting that Callahan limited debate to the elderly, the Johnson says that the reality of the broad expanse of medicine will call for extension to other areas.

Kapp, Marshall B. **Health Care Tradeoffs Based on Age: Ethically Confronting the 'R Word'.** *Pharos* 52(3): 2-7, Summer 1989.

Kapp thinks that rationing depends on acceptance of the concept of relative scarcity of health resources. The demand for services is likely to outstrip capacity since he thinks people do not distinguish between desire for health services and the need for health care. He recommends substantive standards and procedural

rules, saying that policy should not be delegated to insurance companies or health care corporations, but to elected officials who take more responsibility for fair allocation of resources.

Kilner, John F. **Age as a Basis for Allocating Life-Saving Medical Resources: An Ethical Analysis.** *Journal of Health Politics, Policy and Law* 13(3): 405-423, Fall 1988.

The writer examines the primary justifications for using age as a criterion for treatment and the weaknesses of these criteria. After discussing various theories of age resource allocation, he concludes that age should be one tool, not a criterion in its own right.

Kilner, John F. **Age Criteria in Medicine: Are the Medical Justifications Ethical?** *Archives of Internal Medicine* 149(1): 2343-2346, October 1989.

Kilner says the four types of justification proposed for age criteria are length of medical benefit, quality of the benefit, likelihood of benefit, and whether benefit results from treatment. He thinks that the first three are questionable since they rely on statistics and value characteristics instead of individuals, and that the fourth is ethically sound since it is a medical criteria instead of an age criteria.

Kuhse, Helga, and Singer, Peter. **Age and the Allocation of Medical Resources.** *Journal of Medicine and Philosophy* 13(1): 101-116, February 1988.

The authors claim that traditional medical ethics focuses exclusively on the well-being of the individual patient. They recommend fundamental ethical discussions (not economic discussions) including the theory of quality adjusted life years.

Levine, Myra E. **Ration or Rescue: The Elderly Patient in Critical Care.** *Critical Care Nursing* 12(1): 82-89, June 1989.

Levine points out that the same health sciences that made longevity possible confront the old with shrinking funds which would be allocated solely by age. While society condemns suicide, arguments that would ration health care for the aged condone the attitude that the elderly should cooperate in hastening death. She says that critical care nursing has a mission to rescue and

to help relieve suffering; patients in critical care units enter with trust for their well being.

Levinsky, Norman G. **Age as a Criterion for Rationing Health Care.** *New England Journal of Medicine* 322(25): 1813-1815, 21 June 1990. **Rationing Medical Care.** Letters in response to the Levinsky article. *New England Journal of Medicine* 324(3): 193-195, 17 January 1991.

Levinsky doubts that age based rationing would be just; although the intent might be equitable, outcome would tend to favor those of “wealth, social standing, personal connections, articulate appeals to the media or other means” and “the poor, the ignorant, and the disadvantaged would bear the brunt of resource limitations in the future as they have in the past.” He urges that any rationing should allocate resources according to the probability that a patient will benefit rather than his or her age. He says that limitation of the life span by abandonment is from a primitive society; “the wealthiest country in history should not go back to that future.”

McLish, Donna K., et al. **The Impact of Age in Utilization of Intensive Care Resources.** *Journal of the American Geriatrics Society* 35(11): 983-988, November 1987.

This study of 599 admissions to a medical intensive care unit (MICU) and general medical rooms was divided by age groups. Survival declined with age above 70, and do-not-resuscitate orders increased from 10% to 24% between age 70 and age 85. The authors conclude that there was no barrier to access to the elderly in the MICU and that only the DNR status differed in treatment pattern.

Mehlman, Maxwell J. **Age-Based Rationing and Technological Development.** *St. Louis University Law Journal* 33(3): 671-691, Spring 1989.

Law Professor Mehlman questions Daniel Callahan’s proposal in **SETTING LIMITS** to discourage the development of new technologies to extend life since it would deprive all patients, regardless of age, of any benefits.

Menzel, Paul T. **Competing Groups: Age, Severity, and Numbers.** *In his: MEDICAL COSTS, MORAL CHOICES: A PHILOSOPHY OF HEALTH CARE ECONOMICS IN AMERICA.* New Haven: Yale University Press, 1983,

pp. 184-212.

Menzel explains several theories of possible ways to allocate health care. He writes that the “principle of equality thus leans strongly toward a right to a minimal number of years” for each person to live, but that equality is not the only basic principle of a moral life. He thinks that the young will make some general societal compromise. Menzel also discusses severity of illness as a factor in use of health care resources, and the moral dilemmas involved in treating patients with rare diseases and those with common diseases.

Minkler, Meredith, and Robertson, Ann. **Generational Equity and Public Health Policy: A Critique or “Age/Race War” Thinking.** *Journal of Public Health Policy* 12(3): 324-344, 1991.

The authors say that public opinion polls do not support age or race antagonisms concerned with whether the elderly receive health benefits. They claim that false assumptions have been presented on the financial well-being of the aged, and suggest the need for policy that stresses the interdependence of generations.

Moody, H.R. **Generational Equity and Social Insurance.** *Journal of Medicine and Philosophy* 13(1): 31-56, February 1988.

Moody thinks that the elderly are able to lobby policy makers while children, particularly poor or minority children, are not represented in the process. However, he notes that laws in general are not unfair because although they are binding, law is amendable.

Munoz, Eric, et al. **Age, Resource Consumption, and Outcome for Surgical Patients at an Academic Medical Center.** *Surgery* 103(3): 335-343, March 1988.

This study examined resource consumption and outcome by age for surgical patients of all ages. In reviewing the records of 7,341 patients, cost per patient peaked at age 69 and then decreased. Emergency admission was high for those 18-24 years old and those over 75 years of age. The use of the surgical ICU increased steadily to age 64, then plateaued. The financial risk increased with the age of the patient as did length of stay and mortality rate. The authors say that 28.5% of those admitted were 65 and older, and that starting at age 55, the patients began to use a

disproportionate share of resources: health care for those over age 65 accounted for 42.4% of the total cost. The mean cost increased with age until age 75 when it reached a plateau.

Pawlson, L. Gregory; Glover, Jacqueline J.; and Murphy, Donald J. **An Overview of Allocation and Rationing: Implications for Geriatrics.** *Journal of the American Geriatrics Society* 40(6):628-634, June 1992.

The authors provide a brief ethical perspective on rationing and allocation, an analysis of present methods of allocating health resources, and some suggestions which they think would offer a more coherent and reasonable means of allocating and rationing health care. They favor concern for the welfare of the community as a whole, and urge that health professionals and patients abandon the "stark individualism that isolates the clinical encounter" and "acknowledge the role that our values as members of a larger community play in the delivery of health care."

Perrin, Kathleen. **Rationing Health Care: Should It Be Done?** *Journal of Gerontological Nursing* 15(9): 10-14, September 1989.

The author criticizes the concept of a natural life span of about 80 years, saying that there is little scientific evidence to support a claim that people simply wear down and die. She describes and critiques various theories about allocating health care on the basis of age.

Post, Stephen G. **Technology and the Aging Society: Ethics and Public Policy.** *In: BIO-MEDICAL TECHNOLOGY AND PUBLIC POLICY.* Robert H. Blank and Miriam K. Mills, eds. New York: Greenwood Press, 1989, pp. 201-222.

Post looks at three dilemmas: first, whether health care should be rationed on the basis of age; second, the relationship between such rationing and direct termination ("senicide") of the elderly; and third, the status of filial obligations; all of which he says are interrelated. He opposes rationing by age, and thinks all individuals should develop the moral conscience that could have both young or old accept mortality (freely, without any coercion) in the name of justice when no benefits result. Any decision to end life would be voluntary and not by imposi-

tion of an abstract theory of justice.

Reagan, Michael. **Health Care Rationing: A Problem in Ethics and Policy.** *Journal of Health Politics, Policy and Law* 14(3): 627-633, Fall 1989.

This review essay compares the views of Blank, Callahan, Churchill and Daniels.

Samuelson, Robert J. **As America Ages.** *Washington Post*: A17, 25 November 1992.

The article cites various statistics concerned with the increasing numbers of Americans over age 65 and says that the country cannot afford such a huge dependent population. He urges policy changes to prepare for the coming demographic changes.

Schneider, Edward L. **Options to Control the Rising Health Care Costs of Older Americans.** *Journal of the American Medical Association* 261(6): 907-909, 10 February 1989.

Saying that age is not a valid or defensible criterion for rationing health care, Schneider urges investment in research targeted to prevent diseases producing the need for long term care.

Scitovsky, A. A., and Capron, Alexander M. **Medical Care at the End of Life: The Interaction of Economics and Ethics.** *Annual Review of Public Health* 7: 59-75, 1986.

The authors present statistics indicating that persons aged 65-69 have a life expectancy of 16 ½ years (of which 10 will be active) and persons who reach 85 will have 7.3 years (with 60% of that time in need of assistance). They discuss health care normally provided at the end of life, and conclude that only a small part of high medical expenses at the end of life are due to aggressive care of the terminally ill; most seem to be spent for the very ill, but not necessarily dying patient.

Siegler, Mark. **Should Age Be a Criterion in Health Care?** *Hastings Center Report* 14(5): 24-27, October 1984.

Siegler states that medical care for the aged is not only justified, but obligatory. Such care is consistent with universal human rights, compassion for the weak, respect for prior contributions of the elderly, compensatory justice and the universality of aging. He recommends that the

doctor-patient relationship be retained; that quality of care be demanded; and that rationing begin with the strongest, most articulate and most intelligent, not the poor, aged, uneducated, or prisoners.

Singer, Peter. **Review of SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY** by Daniel Callahan. *Bioethics* 2(2): 151-169, April 1988.

The author questions Callahan's theories about the aged and their societal role. He opines that if the old should serve the young when they have reached 75 or 80 years, why wouldn't 100 years be more valuable? Singer notes that the merit of the book is to raise questions about the role of medicine, what we make of lives, and where the burdens of providing medical care should fall.

Smith, Alwyn. **Qualms about QALY's**. *Lancet* I(8542): 1134-1136, 16 May 1987.

Smith gives a clear explanation of the quality adjusted life years' (QALY's) method of allocating resources, and points out that any choice of whom to treat based on cost effectiveness assessment will always favor patients whose age or disease confers longer, better quality survival. He says that the old and very sick are in double jeopardy in such an allocation.

Somerville, Margaret A. **Should the Grandparents Die? Allocation of Medical Resources with an Aging Population**. *Law, Medicine & Health Care* 14(3-4): 158-163, September 1986.

The author indicates that there may be no right answer in allocating scarce health resources, but that "right" decision making principles should be in place. She urges good will and personal conscience, but thinks that these are not enough.

Stanton, Joseph R. **The New Untermenschen**. *Human Life Review* 11(4): 77-85, Fall 1985.

The author is critical of taking life anytime and describes German medical policies in the 1920s and 1930s when certain persons, "Untermenschen", were viewed as a burden and were declared to be devoid of value. He says the Judeo-Christian tradition bestows dignity and a profound respect for life.

Thomasma, David C. **Moving the Aged into the**

**House of the Dead: A Critique of the Ageist Social Policy**. *Journal of the American Geriatrics Society* 37(2): 169-172, February 1989.

Thomasma thinks the basic reason to oppose treating the elderly differently from other citizens is one of social commitment. A rationing plan should be developed, but should not be based on age. Factors such as advance directives, home care, and government assistance for independent living are discussed.

Thomasma, David C. **Setting Floating Limits: Functional Status Care Categories as National Policy**. *Business & Professional Ethics Journal* 9(3 & 4): 133-146, Fall-Winter 1990.

Thomasma favors flexible, floating limits for needs and treatment plans with equal treatment of all persons in the same categories of illness regardless of social status, ability to pay, etc. Wellness and prevention of disease should be emphasized along with quality of life over prolonging life.

Veatch, Robert M. **Justice and the Economics of Terminal Illness**. *Hastings Center Report* 18(4): 34-40, August/September 1988.

Urging conceptual and ethical clarity in addressing the ethics of economics in the care of the terminally ill, Veatch discusses useless and marginally beneficial care. He proposes giving persons priority for health care resources in inverse proportion to their age. Older persons have had a greater opportunity for wellbeing: if two patients, an infant and a old person, are critically ill, the infant has stronger claims on resources in order to have an opportunity for wellbeing over a lifetime. He says that no articulated theory has been developed for deciding which care is to be justly allocated. His theory would place economic considerations in limiting the care of the terminally ill, differentiating between greatest need at a moment in time, and greatest need in terms of wellbeing over a lifetime. Planners "should limit care for terminal illness in the name of justice."

Wetle, Terrie, et al. **Geriatric Medical Decisions: Factors Influencing Allocation of Scarce Resources and the Decision to Withhold Treatment**. *The Gerontologist* 28(3): 336-343, June 1988.

In this controlled study of geriatric care, health

care practitioners and physicians tended to stress physiological aspects, while nurses and social workers stressed psycho-social factors in patient care. The study generally found that health personnel found younger patients more worthy of investment of scarce medical resources: age alone was sufficient basis for triage. The authors conclude that the use of age as a proxy for a variety of problems “is likely to result in erroneous assumptions and inappropriate treatment decisions.”

Wikler, Daniel. **Ought the Young Make Health Care Decisions for Their Aged Selves?** *Journal of Medicine and Philosophy* 13(1): 57-71, February 1988.

Wikler says that at the moment of an actual decision, it is unknown what choices will be made. Precommitment by an individual to a plan to allocate resources optimally over the life span has theoretical advantages but will “not serve a key role in resource allocation for health care in old age.”

### III. Additional Readings

Hayflick, Leonard; Neugarten, Bernice L.; Christiansen, Drew; and Young, Ernle W. D. **Ageing and the Aged.** *In: ENCYCLOPEDIA OF BIOETHICS.* Warren T. Reich, ed. New York: Free Press/Macmillan, 1978, pp. 48-69.

Bayer, Ronald, and Callahan, Daniel. **Medicare Reform: Social and Ethical Perspectives.** *Journal of Health Politics, Policy and Law* 10(3): 533-547, Fall 1985.

Brock, Dan W. **Justice, Health Care, and the Elderly.** *Philosophy & Public Affairs* 18(3): 297-312, Summer 1989.

Brody Jacob A., and Beauchamp, Tom L. **The Best of Times/The Worst of Times: Aging and Dependency in the 21st Century.** *In: ETHICAL DIMENSIONS OF GERIATRIC CARE: VALUE CONFLICTS FOR THE 21<sup>ST</sup> CENTURY.* Stuart F. Spicker, Stanley R. Ingman, and Ian R. Lawson, eds. Boston: D. Reidel, 1987, pp. 3-27.

Callahan, Daniel. **Adequate Health Care and an Aging Society: Are They Morally Compatible?**

*Daedalus* 115(1): 247-267, Winter 1986.

Callahan, Daniel. **Rationing Health Care: Will It Be Necessary? Can It Be Done Without Age or Disability Discrimination?** *Issues in Law & Medicine* 5(3): 353-366, Winter 1989.

Childress, James F. **Rationing of Medical Treatment.** *In: ENCYCLOPEDIA OF BIOETHICS.* Warren T. Reich, ed. New York: Free Press/Macmillan, 1978, pp. 1414-1419.

Daniels, Norman. **Justice Between Age Groups: Am I My Parents' Keeper?** *Milbank Memorial Fund Quarterly* 61(3): 489-522, Summer 1983.

Evans, J. Grimley. **Age and Equality.** *Annals of the New York Academy of Sciences* 530: 118-124, 1988.

Evans, R.L., et al. **Identifying Factors Associated with Health Care Use: A Hospital-based Risk Screening Index.** *Social Science and Medicine* 27(9): 947-954, 1988.

Gillick, Muriel R. **Limiting Medical Care: Physicians' Beliefs, Physicians' Behavior.** *Journal of the American Geriatrics Society* 36(8): 747-752, August 1988.

Jecker, Nancy S. **Appeals to Nature in Theories of Age-Group Justice.** *Perspectives in Biology and Medicine* 33(4): 517-527, Summer 1990.

Jecker, Nancy S. **Towards a Theory of Age-Group Justice.** *Journal of Medicine and Philosophy* 14(6): 655-676, December 1989.

Kapp, Marshall B. **Rationing Health Care: Will It Be Necessary? Can It Be Done Without Age or Disability Discrimination?** *Issues in Law & Medicine* 5(3): 337-351, Winter 1989.

Mehrez, A., and Gafni, A. **Quality-Adjusted Life Years, Utility Theory, and Healthy-years Equivalents.** *Medical Decision Making* 9(2): 142-149, April-June 1989.

Ramsey, Paul, et al. **Scarce Medical Resources. Notes.** *Columbia Law Review* 69(6): 620-672, April 1969.

Rawles, John. **Castigating QALYs.** *Journal of Medical Ethics* 15(3): 143-147, September 1989.

Rich, Spencer. **Bush Turns Spotlight on Health Care.** *Washington Post*: A3, 3 February 1990.

Soldo, Beth; Pellegrino, Edmund P.; and Howell, James T. **Epilogue: Confronting the Age of Aging.** *Socio-Economic Planning Sciences* 19(4): 289-293, 1985.

Thomasma, David C. **Quality-of-life Judgments, Treatment Decisions, and Medical Ethics.** *Clinics in Geriatric Medicine* 2(1): 17-27, February 1986.

(Scope Note 13 was updated by Pat Milmoie McCarrick, a reference librarian at the National Reference Center for Bioethics Literature, who first prepared this Scope Note in March 1990.)