Should Age be a Criterion for the Allocation of Health Resources?

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Health care resources are increasingly scarce as the average age of the population is increasing, expectations of health care are rising, and new medical techniques are constantly being developed, despite a significant increase in the amount of money spent on health resources in most countries. Ageing will present nasty choices to younger taxpayers (pay higher taxes or watch benefits for your parents and grandparents decline) and no less unpleasant ones to older people (pay still more out of pocket or accept a sharp reduction in benefits). It will be no less a bad dream for those providing health care to the elderly: the worst possible combination of sharply increasing and demographically driven need, heightened demand for high-quality care, greatly improved possibilities of beneficial treatment through new technology - and declining funds to make the combination affordable. The debate about health care rationing will become increasingly intense and important in the coming years.

Rationing should be done ethically, but on what grounds? What criterion to use? Should age be the criterion for the allocation of health resources?

It seems that the "special" attitude towards old people has a long historical tradition. The early Japanese are said to have taken their elderly to a mountaintop to die. The Greeks on the island of Ceos required people reaching the age of sixty-five to commit suicide. The Eskimo are reported to have practiced suicide in their old age "not merely to be rid of a life that is no longer a pleasure, but also to relieve their nearest relations of the trouble they give them" (Battin, 1987).

In this context health care must be distributed in a way that achieves maximum benefit and that is seen to be just. Both considerations give the young priority.

Controversy exists about the appropriateness of using age as a criterion for making treatment decisions. Those who are generally in favour of using age as a rationing criterion justify their standpoint in different ways. *Callahan* (1993) suggests age as a categorical limit because it applies to everyone equally, threatens everyone alike, and is usable in a simple and straightforward way. In addition, according to him, those near the natural term of life have a duty to forgo expensive technological treatment in the interest of younger people. *Veatch* (as cited in Shaw, 1994), on the other hand, points out that the old have already enjoyed more community support than the young. *Shaw* (1994) views age as an ethical, objective and cost-effective criterion for rationing health care. At the same time, other assessments of right to treatment often involve subjective judgment of value that we should not make as individual clinicians.

Arguments "against" and arguments "for" ageism in health care

Need for rationing

Efficiency can abolish the need for rationing (Shaw, 1994).

However well we target the resources and however efficiently we deliver medical care, there will always be "two drowning but only one lifebelt". Rationing policies that allocate care away from elderly persons to younger ones increase the effectiveness of these resources and the chances for younger people to reach a normal life span in reasonably good health (Battin, 1987).

Medical criteria

Age per se is a selected non-medical criterion. It is best not identified as a separate selected criterion at all (Kilner, 1990). In different studies, age is found to be of less importance for treatment decisions than presenting illness, previous medical history, and which does not resuscitate status (Nuckton, 1995).

The medical justification for the use of age criteria is: length, quality and likelihood of medical benefit that is for the individual patient. Because the elderly, as a rule, will not live as long as the young, so they

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will not receive benefits from treatment longer than the young. *Prognoses, however, are always uncertain, and length of benefit does not take into account the significance of personhood and the importance of each person's life to that person.*

As for the quality of the medical benefit, the observer's view of quality of life may not correlate well with the patients' subjective experience. The function of medicine should be directed toward making low-quality lives high-quality and not sacrificing low-quality lives to preserve higher-quality lives (Kilner, 1989).

Injustice

Elderly patients have greater chances of getting ill and disability and it is a duty of the society to meet the essential needs of its citizens. A young person may have benefited from much medical care whereas an old one may never have seen a doctor before. Medicine should be there for the need of every person and the maximum future benefit for all the people. If younger patients are given priority, the fundamental interests of older patients are merely not fulfilled to the same degree but indeed, are not fulfilled at all because life is not the sort of thing that can be distributed or re-distributed (Harris, 1994).

A fair distribution of health care resources should involve the consideration of the consequences of the entire lives of the affected people and not just how badly off they are at a particular moment (Kappel and Sandoe, 1994). Fairness requires that we distribute health care resources indiscriminately "so that the fundamental interests of people are fulfilled to the same degree" (Kappel and Sandoe, 1992). Thus, since staying alive is a fundamental interest, other things being equal, different lives should be of equal duration as well as equally fulfilled in all ways. In other words, we should give the young the chance which elderly have already had to live to certain age.

Value of the old

All lives are of equal value. The value of the old lies in their wisdom and their capacity for love, which is as important as the economic value of the young. The only person who can put a value in his or her life is the person living it. Individuals' lives are therefore incommensurable and it is mathematically as well as ethically improper to pile weighty valuation of them together as agreeable commodities (Evans, 1997). As Harris (1985) says:

All of us who wish to go on living have something that each of us values equally although it is different in meaning for each, for some a much richer prize than for others, and none of us know its true value. This thing is "our lives". Whether we are 17 or 70, in perfect health or are suffering from a terminal disease, we all have our lives, however long that turn out to be, we suffer the same injustice if our wishes are deliberately frustrated and our rights are terminated prematurely. (p.89)

However, health care is a limited resource. From the utilitarian point of view, health care should be allocated in the way that can achieve the greatest good for the greatest number of people. If all lives are of equal value more is effected by saving the one with more years left. Ageism makes no assumption concerning the value of a person. It measures years lived and left to live (Shaw, 1994). So the value of life is determined by its length. For Callahan (1993) it is a simple fallacy to think that the only way of respecting the elderly is to provide them with unlimited medical resources equal to those given to other age groups. We can respect different age groups by giving them what will assure a decent life course, not a limitless one. After all, absolute fairness should offer people support for a full and content life (as children, adults, and elderly), not just an extreme attention paid to people in any specific age.

Individual right

Only the patient himself or herself has the right to decide if the treatment he/she has received or has been receiving or will receive is effective. Many studies provide data that the evaluations made by some physicians about patients' wishes differ distinctively with the patients' "real" wishes. The data collected from the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), for example, shows that physicians are less likely to

think that patients want life-extending care when the patients grow older (Hamel, et al., 1999).

Indeed, it would be wonderful if we could satisfy the wishes of all patients. But then why are the health professionals there for? Do we not trust their judgement? They are believed to be highly qualified professionals who swear to act for the benefit of the patients. Thus, patients may have a right to request treatment with perhaps only a single chance of success or which will prolong life only by an hour, but it is time to recognise the limitation of medicine and society has a duty to decline such kind of requests in favour of more reasonable claims.

Ageism not different from racism

A person's age is a physical fact about the person. To use that fact as a basis for the distribution of vital health care resources may seem just as arbitrary and unfair as using physical or biological facts such as race.

A simple example - forced retirement at a certain age - may, however, show that age is a morally different criterion from race. In a situation with a scarcity of jobs it seems fair to force people in public offices to retire at the age of 65. However, it does not seem fair to use race as a criterion for forced retirement. To treat people of a certain age in a special way means that all people will be treated in that way when they reach the relevant age. However, racist policies cannot be redescribed in terms of a similar principle. Thus, formally speaking, there is a clear difference between ageism and racism (Kappel and Sandoe, 1994).

Natural life-span/fair innings

Only the person living a life can say when his or her life is complete. There are physiological, psychological, and social variations among the old - some may not have lived a full life at a particular age (Bowling, 1997).

We have a societal obligation to help every one become an elderly person, to have a long and decent life but we do not have an unlimited public obligation to extend old age as far as either the individual or science might want it to go. Put it in another way, we owe each other a "natural" life-span, not immortality (Callahan, 1993, Goodman, 1994). In each of our lives, a time must come when we have to accept the inevitability of death and when we also have to accept that a reasonable limit has to be set on the demands we can properly make on our fellow citizens in order to keep our lives a bit longer (Williams, 1997). Age-based rationing is not discriminating because each person passes through all age groups in the course of a full life. Thus, differential treatment by age is compatible with treating individuals equally.

Effects on the profession

If age-based rationing is applied, lots of negative effects on the profession would arise. Health care providers could claim that they would be unduly inhibited in their medical practice because they were not allowed to treat the elderly according to their conscientious judgement.

Physicians would be reluctant to be specialised in gerontology if they were forced to terminate care whenever their patients reached the end of their so-called natural life-span.

Coercive, universal, age-based rationing would signal the end of aggressive gerontological research, for there would be little incentive to develop new therapeutic protocols for the old and the very old.

Age-based rationing would prove practically unworkable because it would create a two-tiered system permitting the wealthy to receive medical treatment through an underground health care network while denying it to the poor. Such a system would be dangerous to the elderly who would probably travel far and wide in search for health care. Physicians often accept paying for elderly patients who needed minimal care (Barry, 1991).

The covenant between the physician and the patient takes place within an institutional and social context that shapes their joint decision-making. The economic context should not dominate the social policy or the moral effort of both patients and physicians to control the process of aging and dying with important and fundamental human values will be erased forever. In the end, ageism destroys the opportunity for moral growth at the end of life (Thomasma, 1999).

Decisions in practice should be made on the basis of agreed guidelines rather than subjective views. Age criterion is an objective and useful criterion. Physicians would feel relieved when facing difficult decisions about ending the lives of dying patients and of patients who have been suffering from terminal illnesses for a long time.

Conclusion

Without pretending to be comprehensive, the overview of the different arguments "against" and "for" ageism suggests that a consensus on the matter would be difficult. Both sides have their well defended points. But even if we agree that age-based allocations of health care do not necessarily violate the fair-opportunity rule, they would generally be unjust in many countries at this time. Only if a society takes a systematic approach to ensure equitable access to health care, can it fairly decide the issues surrounding age-based rationing, and even then difficult questions would remain. Proposals for age-based rationing could perpetuate injustice by stereotyping the elderly, by treating them as scapegoats because of increases in health care costs, and by creating unnecessary conflicts between generations (Beauchamp and Childress, 1994).

The primary purpose of any social policy governing care of the elderly ought to be patient-tailored care. Increasing age should be accepted as an increasingly important factor in some clinical decisions but actual age limits should be advisory. The application of any code depends on circumstances and judgment. There can be no absolutism at the bedside.

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