The ethics of age discrimination and cost-benefit accounting

Richard Maundrell and **Jaro Kotalik** propose a system for allocating scarce health care resources

The Ministry of Health wishes to implement a new health care programme, but money is scarce. In contention for funding are a programme for the early detection and treatment of Alzheimer disease and a programme for suicide prevention in children and young adults. The government elects to implement the suicide prevention programme.

A hospital board must reduce operational costs in order to avoid running a deficit. The board must choose between scaling down their neonatal intensive care programme or eliminating their surgical hip replacement programme. The board decides to terminate their hip replacement programme.

A physician has one bed available in the ICU but two patients who require ICU treatment. One is an elderly woman, who has always been healthy but who now has severe pneumonia and needs artificial respiration support. The other is a young man with chronic and progressive liver and renal failure who has been admitted on numerous previous occasions in the attempt to stabilise his condition. The physician decides to assign the bed in the ICU to the young man while treating the woman in the general medical ward.

Such scenarios illustrate the three distinct levels at which decisions about the allocation of medical resources must be made: macro-allocational decisions by the government or its ministries, meso-allocation at the level of individual hospitals, and micro-allocation by individual physicians' at the bedside. A consideration which may arise in each of these decisions is the thought that the needs of the elderly are somehow less important than those of the young. But the idea of discriminating in the allocation of health care on the basis of age raises serious questions about fairness.

There is a certain *prima facie* plausibility to the notion that, under conditions of scarcity, a just health care system would give priority to ensuring that as many people as possible live out their natural life span before resources are devoted to extending the lives of the elderly beyond it. Moreover, in some reasonably foreseeable circumstances, the elderly themselves may not want the intensive acute care that a system based upon the principle of equal treatment for all might recognise itself as obliged to provide. Ethicists such as Norman Daniels and Daniel Callahan have argued at length and with conceptual sophistication that it is defensible to discriminate in the delivery of health care on the basis of age (1).

Questions of fairness in resource distribution are a fundamental concern in public health care systems funded through general tax revenues. In such systems, both the tax payers who support them and the clients they serve are removed from priority-setting decisions by political and administrative arbitrators. Resources must be allocated in a way that is as fair as possible to all concerned. Justice in a public health care system must be achieved by design and by the deliberate application of sound principles of distributive justice. (This is not to imply that market mechanisms would necessarily produce a just distribution of medical resources, or a distribution superior to that produced by government management. The point here is only that, in a market system, arbitrators play a more limited role and their decisions have correspondingly less significance so far as justice in distribution is concerned.)

The veil of ignorance

Norman Daniels has argued that decisions about justice in the allocation of health care resources can usefully be addressed by employing, as the decision mechanism John Rawls' hypothetical "veil of ignorance". Rawls offers his procedure as a thought experiment by which one sets aside considerations unique to one's own self or situation in order to consider questions concerning principles of fairness. Daniels asks us to assume, as we place ourselves behind the veil of ignorance, that the uniquely essential aim of medical care is to restore "normal" physiological functioning. He suggests that questions of how health care might best be allocated should be based on a consideration of the rational individual's "fair lifetime share of health care". The veil of ignorance insures impartiality; whatever share one might allocate to oneself would be that which one would want for any other participant in the system.

Daniels' own application of this procedure results in justifying ageist rationing, as he illustrates, using a hypothetical example:

Imagine there is a disease around which would kill everyone at age 50, but a drug is available in short supply. We can give a half-dose to everyone, and they will then live to 75 and die; or we can give a full dose to half the population by lottery, so that half die at 50 and half at 100 (2).

The "half-dose to everyone" option is analogous to a system in which health care resources are allocated with a view toward enabling as many of its clients as possible to live to the age of

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75. The lottery option is the analogue of a system in which its clients have equal access to medical resources. Daniels suggests that a rational person would prefer the former - the ageist - scheme over that of equal access.

Although Daniels' system allows for discrimination against the elderly in the allocation of resources, he argues that his so-called "prudential life-span" theory is not invidiously discriminatory. The decision procedure used to select the allocation of resources incorporates the premise that everyone can expect, in the normal course of events, to grow old. Therefore, ageist discrimination cannot be unjust in the way that, say, sexism or racism is.

Daniels bases his account on the claim that a health care system should aim at equality of opportunity for its clients in respect to the "normal opportunity range", understood as the "array of 'life plans' reasonable persons are likely to construct for themselves." (3) Medical care is aimed at restoring the normal functioning which will enable its recipients to act on life plans fitting within their normal opportunity range. Daniels' justification of age-based rationing is grounded in the claim that "prudent deliberators would prefer a normal life-span to one which would give them a reduced chance of reaching a normal life-span but a greater chance to live an extended life-span once one's normal allotment is reached." (4) He acknowledges that, for some individuals, life after the age of 75 can be productive, healthy and rich in meaning, but a prudent deliberator behind the veil of ignorance would have to take into account the fact that life after 75 is far more likely to be fraught with disease and disability than her life would have been before that age. Accordingly, the deliberator would weight medical care toward the early and middle years when life plans were most likely to be fulfilled. The important theoretical point in Daniels' defense of ageist discrimination is its conversion of the client's claim to health care system from one based on need to one grounded in equality of opportunity.

Daniels admits that his argument is easily misinterpreted and does not readily lend itself to "non-ideal" contexts (5). However, his concern is with making a case for the idea that age-based discrimination can be part of a just distribution of medical resources and that age-based discrimination can be practised as a matter of justice rather than efficiency alone.

Those who are not convinced that the veil of ignorance is a reliable decision procedure will not trust any conclusion reached through its application. However, even if we allow, for argument's sake, that Rawls has got it right and that Daniels, in his application of Rawlsian methods, does as well, serious problems with Daniels' account stem from his first principles.

First, his claim that a health care system should conceive its primary goal as that of equal access to normal functioning is both unsupported and contentious. While it is undoubtedly true that "acute care" is aimed at restoring normal functioning, acute care is only one of the many functions performed by a health care system. Daniels does not explain why acute care should have priority over other ends which the medical care system might serve, but a prudent person placed behind the veil of ignorance would likely want to provide for such non-opportunity related health care services as chronic or palliative care. A system which supplied medical care on an equality of opportunity basis would focus its resources on acute care. The question is whether the resulting pattern of distribution would appear desirable, let alone just.

> In the interest of efficiency as well as fairness, expensive but marginally beneficial treatment might be withheld. However, policies which discourage the funding of such treatments can apply to patients of any age.

Second, Daniels links clients' rights to acute care with clients' life-plan opportunities. However, the link between the right to health care and life-plan opportunities is based on a sense of justice which could work to the disadvantage of a number of groups, and weaken their claims to medical care. For example, the very young who have not yet developed the mental capacity for "life-plan opportunities" might have a diminished claim to medical resources, as would those who suffer from substantially impaired mental capacities. At the very least, a different set of principles altogether would have to be applied in the case of those who do not have the capacity for rational decisions concerning life-plans. Preferences conceived from behind the veil of ignorance by a rational deliberator would not straightforwardly apply in such cases. This set of principles would take us away from Daniels' preference-based system back to the needs-based approach that most medical care systems currently embrace.

Finally, Daniels attempts to make his case for ageist heath care rationing a matter of justice, but there are strong pragmatic grounds for discriminating against the elderly in the allocation of health care. There are few attributes in the client population as identifiable and objective as age. The elderly are particularly vulnerable targets in health care rationing schemes because age is not only a convenient way to distinguish between clients, but ageist discrimination is already a well entrenched legal principle in many countries. For example, many societies accept the principle of a compulsory retirement age. It may be tempting to argue that, beyond a certain age, one should not expect to receive expensive medical care aimed at prolonging one's life.

Cost-benefit accounting

One way of calculating value in the allocation of health care resources is by measuring money spent against returns measured in the potential productivity of lives. A system which rationalised the expenditure of medical treatment to maximise the social product might allocate fewer resources to the elderly on the basis of such cost/benefit accounting (CBA) procedures. Other things being equal, a life saved at the age of 20 represents a greater benefit to the social product than one saved at the age of 75. Therefore, outputs can be maximised and the efficiency of the system enhanced by concentrating expensive or scarce medical resources on the young.

Efficiency, however, is not an end in itself. A system driven by the principle of efficiency alone would entail consequences inconsistent with any reasonable sense of justice. For example, chronic diseases would count as a poor investment and might not be treated at all, as would diseases which require expensive treatment but which have a high fatality rate such as AIDS or lung cancer. Questions about efficiency have to be addressed within the context of which of the many possible outputs are preferred. Medical care systems typically pursue a variety of "outputs" and must divide resources between various ends including disease prevention, acute care, chronic care and palliative care. These are matters of administrative policy, which are in turn driven by a mixture of political, social and ethical considerations. (Given that a medical system pursues a number of ends, of which the prolongation of life is only one, there are ways by which priorities might be established between competing ends. Daniel Callahan has suggested criteria by which this might be done (6). Once the system has adopted a policy it can then go about calculating the most efficient means by which to deliver it.

There are good utilitarian reasons for investing medical resources in the young. Since they can be expected to live longer, investment in their health care will have a multiplier effect in returning benefits to society: a longer period of contribution to society as tax-payers, parents, consumers, and so forth. One might argue as well that life is actually more valuable to the young. But principles of efficiency and utility will not suffice. It might make sense on a CBA basis, for example, to encourage young people to take up smoking. Since smokers tend to die from causes related to tobacco use in late middle age, the system would (assuming that tobacco smoking related illnesses are not more expensive to treat than the diseases that non-smokers develop) benefit from multiplier effects that would include decreased health care costs for the elderly simply by diminishing the number of elderly.

On the other hand, CBA-type decisions which work to the disadvantage of the elderly are not necessarily unfair. It is entirely reasonable to discourage the commitment of resources to heroic interventions on behalf of patients who can be expected, even should such measures be successful, to die soon after receiving them. In the interest of efficiency as well as fairness, expensive but marginally beneficial treatment might be withheld. However, policies which discourage the funding of marginally beneficial but expensive treatments can apply to patients of any age. Where the same criteria are applied to all in rendering treatment decisions, the system is not allocating resources on an "ageist" basis, even if age might be a factor in deciding whether a treatment will be of "marginal" benefit. The principle that it is unfair to commit large resources to the treatment of the elderly for marginal returns in the prolongation of life can be preserved without opting for ageist rationing schemes. A system based on sound need assessment procedures in conjunction with CBA will avoid the problem of expensive but marginally beneficial treatment without entrenching discriminatory principles: principles that are not only unfair but which would bear with them their own moral dilemmas.

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5. Ibid. 218.

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