
Debate

Response to Roger W Hunt

Daniel Callahan *The Hastings Center, New York, USA*

Author's abstract

A response to a critique by Roger W Hunt of my views on the eventual likely need to use age as a standard for the allocation of expensive, high-technology, life-extending medical care for the elderly.

The response encompasses three elements: 1. that while the elderly have a substantial claim to publicly-provided health care, it cannot be an unlimited claim; 2. that a health care system which provided a decent, coherent set of medical and social services for the elderly would be sufficient, even if some limits had to be set; and 3. allocation and rationing decisions should not be made by individual doctors at the bedside but by regional or national policy.

Since I published *Setting Limits* (1) six years ago, I have been endlessly bemused by the assorted distortions of the argument I tried to make in that book. Mr Hunt's version of what I said, however, must rank among the most inaccurate renditions of my position, as if in a rush he chose to read every other page of the book, leaving out half of my position. If that is not quite satisfactory for me as the author, it has made his task of criticism much easier. He has neatly dispatched *his* version of my book. I welcome this opportunity to present *my* version.

In response to his article, I want first to summarise what I was trying to say in the book. Then I will take up some of his specific points. My argument in the book was this:

Over the next twenty to forty years the United States (and other developed countries as well) will be faced with the combination of a greatly increased proportion of elderly together with increasingly expensive technologies to care for them. Using government and demographic data I pointed to some ominous projections about the cost of medical care for the elderly over that period of time, including a near-term bankruptcy in the United States of the Medicare Trust Fund to pay for that care.

Given these projections, I contended that we should begin now, before the crisis is fully upon us,

to change our expectations about health care for the elderly in the future. I stressed the *trend* in the development of expensive technologies, not their present costs. I said that we needed to re-think two firmly entrenched ideas. The first is the notion that we should try endlessly and expensively to modernise old age, to turn old age into a permanent middle age. We should instead accept aging as a part of life, not just another medical obstacle to be overcome. The second idea I went after was the view that there should be no limits to the claims of the elderly as a group to health care under *public* entitlement programmes, that only their individual needs and desires should count.

I argued instead that, while the elderly have a substantial claim upon public funds for health care, it is not and cannot be an *unlimited* claim. Not only is an unlimited claim likely to be utterly unaffordable, it would place an unjust burden on the young, whose taxes must pay for such a claim. My focus, then, was on entitlement programmes and on devising programmes that would be fair, balanced, and subject to reasonable limitations.

More specifically, I was looking for a public policy that: (a) guaranteed the elderly along with everyone else access to universal health care (lacking in the United States); (b) helped everyone avoid an early, premature death; (c) greatly strengthened long-term and home-care support of the elderly; and (d) used age as a key standard in cutting off expensive life-extending technologies – but using it as a standard if and only if the other reforms have been put in place first. The goal I have in mind is a balanced, affordable system of care for the elderly, aiming to achieve a good balance between length of life and quality of life. My aim is not to cut present costs or scale-back current care for the elderly; if anything, we need to spend more now. I am instead looking for a way to control the unbridled escalation of costs in the future, to keep health care for the elderly from running away with the entire health care system.

I held, finally, that these changes should be effected not by compulsion, but democratically, preceded by a 20–30 year period of changing the way we think about health care for the elderly. We should impose an age limit upon ourselves, using legislative

Key words

Age; allocation; costs; needs.

means to do so. As I said in my preface, 'what I am looking for is not any quick change but the beginning of a long-term discussion, one that will perhaps lead people to change their thinking and, most important, their expectations, about old age and death' (2).

How, in a general way, does this version of my book differ from that sketched by Mr Hunt? Mr Hunt totally ignores the data I present about the long-term economic problem, and at no point joins the argument about how we are to deal with that problem in the years ahead. He thus overlooks one of my major reasons for writing the book. Mr Hunt no less ignores almost altogether the first four chapters of the book, over half, which focuses on the many distorted ways we have come to think about aging, and how we have allowed medical day-dreams and scientific fantasies to lead us to think it can be banished or be made inconsequential.

By its stress on the heterogeneity of the old, and the idea that getting sick and getting old can be sharply distinguished, modern aging philosophies have – in the name of anti-ageism – all but banished aging as a meaningful human condition. Mr Hunt's viewpoint, wholly individualistic in its orientation, and indifferent to the needs of other age groups, perfectly exemplifies the kind of distortion I was trying to address. Such a viewpoint, I believe, does nothing to help us find the meaning and significance of old age in our times, and nothing to help us address the question of what constitutes a fair and reasonable share of resources for the old.

Let me now address some of Mr Hunt's specific points.

1) *The power of biotechnology*: Mr Hunt says that I overestimate 'the power of biotechnological medical practice to extend human life'. I do not overestimate that power; on the contrary, I agree that lifestyle, nutritional, and other changes made the greatest historical difference in overall life expectancy (though technology began adding to that difference by the 1960s). My point is a different one: that the cost of using technology now to extend the life of the old will be both highly expensive and not very productive of greater life extension – incremental gains in life extension at exponential economic costs. It is for just that reason that a limitation on high-technology life-extending care for the elderly makes most sense, spending money instead on more basic health care (and social) services.

2) *Covert age-rationing*: Mr Hunt is correct to note that age discrimination already exists and I never said otherwise. I object to that. Far better would be a system of age-rationing that is open and democratically achieved, not the covert, irrational kind that is now common.

3) *Costs of different forms of care*. I did not argue, as Mr Hunt and Dr Levinsky (3) assume, that a reduction in high technology care would save much money *now*. My book was not interested in the

present, but in the likely future situation. It is the *trend* in high-technology medicine that was my focus, a trend that is now seeing (at least in the United States) a sharp increase in the age at which expensive high-technology interventions are taking place: the fastest growing group of those on dialysis are those 75 and older; coronary artery by-pass surgery is now common among octogenarians; intensive care units are filled with older and sicker patients; and so on. Of course long-term and palliative care are labour-intensive and expensive. But that is what the elderly increasingly need – and I do not believe we can provide both that kind of care and continue to devise ever more expensive ways to employ technology to extend life.

4) *Coping with death and suffering*: As I have been in the field of bioethics since about 1965, I have been both an observer of, and a participant in, the rise of the hospice and thanatology movements. They have been important and helpful. But the fact of the matter is that they have not made a decisive difference yet in the way people die. Less than 10 per cent of the American population has signed advance directives, and no more than 10 per cent are cared for by hospice programmes in their dying. Many doctors with long experience tell me that it is harder to care for dying patients now than it was 20 years ago: the decisions are more complex, more ambiguous and often more controversial. Do we talk openly about death? Not much, at least in the United States. We talk about our *choices* in dying, but not about death and its meaning. I have just completed a new book, *The Troubled Dream of Life: Living with Mortality* (4), a main point of which is to urge the need to think about death itself, not just the civil liberties of our choices about dying.

5) *Collectivism and utilitarianism*: I consider myself neither a collectivist nor a utilitarian. What I do believe is that, in attempting a fair allocation of resources, those who fashion public policy must focus on the public interest, not exclusively on individual welfare case-by-case. It is necessary, in that perspective, to consider the welfare of groups, asking both about their needs as groups and their comparative needs as different groups. Society is made up of both individuals and groups, and neither is reducible to the other. The elderly are individuals, but they are also *elderly* individuals, and as such have different needs from young individuals. That is why we have the fields of gerontology and geriatrics, and special social and medical programmes for the elderly. Decent public policy must balance group and individual needs; neither should be allowed total dominance.

Mr Hunt says that I regard 'elderly people as the means to a greater social good, rather than as ends in their own rights. He ignores the interests and claims of elderly individuals, suggesting they should be sacrificed for the benefit of others'. Mr Hunt is wrong on both counts. The elderly are 'ends in their own

right', and they should not be sacrificed for anyone. What I deny is that a dedication to those values requires us: (a) to allocate unlimited resources to the aged, regardless of the needs of others; (b) that respect for others, old or young, entails the pursuit of unlimited life extension; and (c) that an effort to balance the needs of different age groups is the equivalent of sacrificing one group in the name of the other.

A central problem here is: just what are the 'individual needs and interests' of the elderly? I do not believe that there is an unlimited *need* for high-technology, life-extending medicine, nor do I believe it is in the interests of the elderly so to construe their human and medical needs. Mr Hunt is free to disagree with me on that. But he should at least come to grips with the arguments I present against the efforts to modernise aging, and my challenge to the assumption that respect for the elderly requires the unlimited lavishing upon them of ever more expensive health care. That is not what the elderly themselves say they want, and for good reasons: it offers no assurance of a better, more satisfying life.

6) *Respect for autonomy*: No political or moral theory I have ever heard of has been able to find a perfect way simultaneously to maximise autonomy and equity. Life in human communities requires that, from time to time, we limit our own claims to autonomy in order that there be a just distribution of limited resources. I believe that it will be necessary to set limits to health care of the elderly. That means that some claims of autonomy will have to be set aside – but set aside in order that the needs and autonomy of others have a chance to flourish. I argued in my book that the old have a duty to the young not to make demands that will harm the young; and that the young for their part have some significant duties to sustain the welfare of the old. The young should rein in their own autonomous claims for the sake of the old; and the old should do the same for the young.

I stressed throughout the book that I want the different age groups to do this voluntarily and democratically. It is not the autonomy of others we should aim at limiting, but our own autonomy. I was aiming, that is, to effect a self-imposed limitation, not one coercively imposed: we should agree, as a community, to set limits on our individual demands. In defence of such a self-imposed limitation I offered the following argument: it would be a selfish and unjustifiable exercise of autonomy for the elderly to demand unlimited medical care regardless of the expense or burden upon others. I would consider it no less selfish and unjustifiable for the parents of a very low-birthweight baby to insist, in the name of their autonomy, that their baby be rescued regardless of the cost or burden on society.

7) *Compulsory passive euthanasia*: Mr Hunt has conflated two distinct issues, that of the allocation of resources and of individual euthanasia. A limitation

of health care resources is in no sense 'compulsory passive euthanasia', which implies a deliberate effort to shorten a life by the withdrawal of care. I make two additional points in response. First, it is by no means inevitable that the shift I propose, with a greater emphasis on quality of life, will necessarily shorten life expectancies in general; I believe it will not. The lives lost by restrictions on high-technology medicine may well be offset by gains in life expectancy because of the other improvements I propose in health care for the elderly. Life expectancies in the United States and Great Britain are almost identical, and this despite the fact that the elderly are routinely denied many forms of high-technology medicine in England that are regularly available to their counterparts in the United States. The superior primary-care system, and long-term and home care, account for the overall good English outcome.

Second, while some forms of allocating resources may be unfair, that does not make them acts of euthanasia. Any form of allocating resources will inevitably entail some limitations on meeting some need or demand. Are we to say that the legislator who takes money away from a health budget for the sake of improving the education of children is engaging in a form of euthanasia? We know, statistically speaking, that there are any number of ways of saving life in a society. Is a vote in favour of parks an act of euthanasia if the same amount of money might, statistically, have marginally reduced the highway death toll?

8) *The heterogeneity of the elderly*: If Mr Hunt had read pages 120–123 of my book, he would have seen that I directly address the objection that the heterogeneity of the elderly militates against an age limit. Of course the elderly are different as individuals, but that by no means precludes the use of age as a standard. I wrote the book in part because, as a group, the elderly are coming to consume a disproportionate share of resources; and that is true however varied the elderly as individuals may be. It is no less true that the greatest increase in health care costs in the years ahead will be incurred by the aged as a group.

For public policy purposes there is no generalisation that is more solid than the following: health care for the elderly is significantly more expensive than for younger age groups. That is why health care for the elderly has become a serious policy and allocation problem for every developed country with a growing number and proportion of elderly. The fact that the elderly are individually different in no way lessens the general economic problem; it is their costs as a group, as an age cohort, that matters. That is why I focused on age as a key policy variable, not on wrinkles or hair colour, neither of which have any policy or economic significance.

How, then, are we to deal with the health care needs of the aged as a group, to set some limits to the

potentially crippling costs that lie before us in the years ahead? That was the problem I set out to solve. I chose age as a limit-setting standard for three reasons: (1) it is a clear and visible standard, one that can apply to everyone; (2) because, if a society can help individuals to live a long life by its overall health policies, particularly helping them to avoid a premature death, then it will have discharged its principal obligation to them; and (3) because the possibility of spending money to extend individual or group life expectancies in old age is, in the nature of the case, infinite. No society can be obliged to undertake the pursuit of such a possibility. In sum, society has an obligation to help us become old people in the first place, to make it from youth to old age. It cannot have an unlimited obligation thereafter to continuing extending our life in old age.

Where might the age cutoff be set? I suggested the 'late 70s or early 80s', saying that the specific age should be left to public decision and debate. My working assumption was that, if society can help us get that far, then it will have treated us fairly, even if we vary as individuals in our life goals and plans. It is not the duty of government to tailor its welfare and entitlement programme to our personal lives and agendas in all their variation and idiosyncracies.

9) *Age and the doctor-patient relationship*: The need to ration and limit health care for all age groups in the years ahead will necessarily limit the discretion of both doctors and patients. There is, moreover, general agreement in the United States that doctors at the bedside should not be rationing agents, using age or any other standard. Any rationing standards should be set as the outcome of public, democratic discussion and imposed upon all equally. By locating the decision-making process at that level, the doctor

is relieved of personal responsibility for the decisions, the public is protected against capricious and erratic clinical standards, and there is a better chance of everyone being treated fairly.

I finish my response to Mr Hunt with a final question. If we eventually agree that the costs of health care for the elderly will, in the name of justice and economic prudence, require some form of limits, what is the best way of setting them? Anyone can, like Mr Hunt, think up plenty of objections to the use of age as a standard – particularly when that standard is compared with some ideal world, where each individual need is met regardless of costs, where autonomy reigns supreme, and where no limits have to be set at all. But the world we will have to live in is not likely to present us with such pleasant choices. Any serious form of setting limits will be unpleasant and potentially unfair to some. If Mr Hunt does not like my way of setting limits, then let him propose some of his own. Then we can compare his unpleasant way of setting limits with my unpleasant way. That is the argument we should be having.

Daniel Callahan is Director of The Hastings Center, New York, USA.

References

- (1) Callahan D. *Setting limits*. New York: Simon and Schuster, 1987.
- (2) See reference (1): 10.
- (3) Levinsky, N G. Age as a criterion for rationing health care. *New England journal of medicine* 1990; 322, 25: 1813–1815.
- (4) Callahan, D. *The troubled dream of life: living with mortality*. New York: Simon and Schuster, forthcoming 1993.