Our Hearts Were Once Young and Gay: Health Care Rationing and the Elderly

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OUR HEARTS WERE ONCE YOUNG AND GAY: HEALTH CARE RATIONING AND THE ELDERLY

George P. Smith, II*

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But neither one person, nor any number of persons, is warranted in saying to another human creature ripe in years, that he shall not do with his life for his own benefit what he chooses to do with it.

John Stuart Mill, *On Liberty*

I. INTRODUCTION

It was not long ago that the fusion of old age and death was anachronistic. Indeed, death was not particularly associated with aging. Advanced years represented an ability to withstand the numerous perils of infancy, childhood, and adulthood to which most others succumbed. Today, however, aging has become commonplace, and a person's natural life easily spans seven or eight decades. The advancement of medical knowledge and technology is only one factor contributing to this longer life span. In addition, improvements in public health measures, such as housing and sanitation, and in socio-economic condition have lead to a proportionate increase in the average life span in the United States. The traditional perception of health care obligations towards the elderly continues to evolve as the number of aging steadily grows. Coupling this evolving duty towards elderly citizens with an increasingly complex health care system presents today's health care providers with unique ethical dilemmas centered around paternalism, costs, and death.


2. Id. “In 1900, the average American died in the fourth decade [of life].” Sheryl A. Russ, *Care of the Older Person: The Ethical Challenge of American Medicine*, 4 ISSUES L. & MED. 87, 88 (1988). The elderly did not need to be successful in order to be respected. Rather, reaching old age was such a rarity that it commanded respect in and of itself. May, supra note 1, at 31.

3. May, supra note 1, at 31. “Actually, the average American life span is eighty five years and not expected to change much in future years. Most researchers believe that this is close to the ideal human life span.” Russ, supra note 2, at 87-88.


5. See Marshall B. Kapp et al., *LEGAL AND ETHICAL ASPECTS OF HEALTH CARE FOR THE ELDERLY* 4 (M. B. Kapp et al. eds., 1985) [hereinafter LEGAL AND ETHICAL ASPECTS]. Health care costs have been rising steadily. Between 1980 and 1990, national expenditures for health care rose at an average annual rate of 10.4%, ballooning into a 12.3% share (or 733 billion dollars) of the gross national product (GNP) by 1990. Joshua M. Wiener, *Rationing in America: Overt and Covert*, in *RATIONING AMERICA'S MEDICAL CARE: THE OREGON PLAN AND BEYOND* 12, 13 (Martin A. Strosberg et al. eds., 1992); Janice Castro, *Condition: Critical*, TIME, Nov. 25, 1991, at 34. This figure could easily reach 15% of the GNP by the year 2000. HOUSE COMM. ON WAYS AND MEANS, 102D CONG., 1ST SESS., HEALTH CARE RESOURCE
The typical administration of elderly health care is no longer performed at home or in a doctor's office. Rather, it has become an expansive system of high-cost technology, involving an unprecedented number of health care professionals. Consequently, medical decisions pertaining to elderly patients are often made by individuals not directly affected by those decisions. Diagnostic and therapeutic procedures are performed by numerous physicians or pursuant to their instructions, resulting in a diminution in the autonomy of patients and an alarming waste of limited resources.

II. ELDERLY ACCESS TO MEDICAL CARE

Although no rigid guideline delineating society's obligation to provide health care exists, at a minimum Americans are entitled to an adequate level of care without being saddled with excessive financial burdens and administrative complexities in the delivery of that care. Fulfilling this ostensibly simple mandate, however, presents an enormous challenge. The need to allocate limited financial and human resources increasingly clashes with the desire to provide health care resources to the elderly who are beyond their years of economic productivity. As a result, health care professionals face the difficult task of balancing efficient distribution of limited health care resources to the elderly with society's other priorities. This places a unique

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Between 1984 and 1989, the average annual health insurance premium per employee more than doubled from $1453 to $3117. The Changing Face of Health Care: The Movement Toward Universal Access: Hearing Before the House Select Comm. on Children, Youth, and Families, 101st Cong., 1st Sess. 6 (1989). Given this rise, many employers who do provide health insurance and compete globally argue that the rising cost of providing health care to their employees contributes significantly to their inability to compete effectively with foreign businesses. See The Health Care Crisis and the American Family: Hearing Before the Senate Comm. on Labor and Human Resources, 102d Cong., 1st Sess. 64 (1991).

In principle, at least, the goal of a national health system is greater efficiency in the treatment and cure of disease as well as in the control of chronic conditions. MARGARET P. BATTIN, THE LEAST WORST DEATH 81 (1994). See generally GEORGE P. SMITH, II, LEGAL AND HEALTHCARE ETHICS FOR THE ELDERLY (1996).

6. Joanne Lynn, Ethical Issues: Equitable Distribution and Decision Making, in LEGAL AND ETHICAL ASPECTS, supra note 5, at 16-17. Such disaffected decision making is more prevalent when taxpayer money is used for the payment of medical expenses. Id.

7. See Paul A. Kerschner, Assuring Access to Long-Term Care: Legal, Ethical, and Other Barriers, in LEGAL AND ETHICAL ASPECTS, supra note 5, at 25 (citing the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services 4-5 (U.S. Gov't Printing Office, Washington, D.C. 1983)).

8. Interestingly, Dr. Hiroshi Nakajima, a Director General of the World Health Organization, has stated that "the right to a long life, which might theoretically be averaged at 100 years, is a basic human right of every individual." Daniel Callahan, Modernizing Mortality: Medical Progress and the Good Society, 20 HASTINGS CENTER REP. 28, 28 (1990).
burden upon health care professionals, particularly physicians. Today’s physician must become the “gatekeeper,” a designated guardian of society’s resources. It is reasoned that the physician can be forced to conserve society’s limited health care resources by controlling the administration of medical treatments.

Inevitably, the demands placed on health care administrators results in a balancing test that challenges the breadth of elderly health care services by forcing difficult and sometimes controversial health care decisions in order to avoid an economic catastrophe.

A. The Definition of Basic Health Care

As advocated in John Rawl’s theory of distributive justice, justice must prevail over efficiency and liberty must prevail over social and economic advantage. When applied to basic health care, the theory provides that everyone, the poor, the rich, the young, and the old, has an unqualified right to health care.

The most basic care is care that saves someone’s life, resulting in a quality of life that is acceptable. Furthermore, according to public opinion, no one who wants care should be denied critical or lifesaving care because of the inability to pay. Because the cost of health care is excessive and outruns the general rate of inflation, the challenge has become one of true distributive justice, that is, equitably allocating available health care resources to provide at a minimum an adequate level of just or humane care.

9. Edmund D. Pellegrino, Rationing Health Care: The Ethics of Medical Gatekeeping, 2 J. CONTEMP. HEALTH L. & POL’Y 23, 26-29 (1986). The physician today controls approximately 75% of health and medical care expenditures. Id. Dr. Pellegrino espouses three forms of physician gatekeeping: (1) de facto gatekeeping, whereby the nature of health care administration imposes upon the physician a moral obligation to use both the individual and society’s resources optimally; when ethically performed, the role of a de facto gatekeeper does not conflict with the patient’s medical well-being since the doctor’s and the patient’s interests coincide; (2) negative gatekeeping, in which the physician is placed under constraints of self-interest to restrict the use of health care services of all kinds, especially those with the highest costs; and (3) positive gatekeeping, whereby the physician is constrained to increase rather than decrease a patient’s access to health care services. Id.

10. Id. at 23-24. The gatekeeper theory presumes that the physician will control health care rationing by regulating tests, treatments, operations, hospitalization, and referrals for consultation. Id. But see Mary Beth Franklin, Senate Warns of Shortage of Doctors for the Elderly, WASH. POST, May 14, 1996, at 2 (Health).


13. See Fredrick R. Abrams, The Basis of Basic Care, 7 FRONTLINES 2, 2 (1990). Under this theory, anyone with the will to live should be able to do so. Thus, in cases of high quadriplegic injuries costing $300,000 in the first year and an additional $100,000 annually, this “basic care” should be provided to those choosing to respond to the challenge of life. Id.
without excessive socio-legal and financial burdens.  

In formulating the standard of basic care, society must address the essential, yet problematic, element of human health needs. Health needs are tremendously complex and can neither be assessed in isolation from other needs nor dispensed with entirely. The basic need undergirding the entire enterprise of medicine is clearly identifiable, that being, the patient's need to avoid illness and death. A basic package of health care services made up of known, efficacious treatments is the most pragmatic response for fulfilling this need. Taken even further, basic care must reflect the values and culture of the society in which it is being administered, balance an entire range of societal needs, and even more importantly, draw only upon available resources.

Basic health care must recognize an individual's pain and suffering and provide a level of care feasible within the functioning of societal institutions, that is, social, cultural, and political institutions. It must focus on enhancing the quality of life rather than on holding off death or preventing illnesses and disabilities associated with old age rather than on high-technology cures. Basic health care must enhance the general level of public health rather than devote excessive resources to the special, cumulative needs of an individual — "a more rounded and coherent" level of basic health care. In essence, basic health care means the fulfillment of a reasonable minimal level of individual need while striving for the common good rather than individual rights.

The common good is caring for those in need. This level of basic care transcends the boundaries of individualistic treatment and represents for ailing patients a combination of accessible medical, social, and emotional care.


16. *Id.* at 7.

17. *Id.*


19. Callahan, *supra* note 14, at 8; see DANIEL CALLAHAN, SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY 240 (1987). Perhaps the best way to describe this level of care is by drawing an analogy with the provision of fire and police protection. The fire department serves people equally, regardless of wealth or individual need. Thus, it is essentially an egalitarian model that assures a minimum level of protection for all, even though it is not specifically tailored for individuals. Callahan, *supra* note 14, at 8.

20. Callahan, *supra* note 14, at 8-9. It is well established that medicine is a finite science and each person, at some point, will need care. *Id.* Interestingly, the Center for Disease Control and Prevention has reported that since 1980, the suicide rate among the elderly has jumped 9%, with the number of suicides for those 65 years of age or older rising 36%. Don Colburn, *Suicide Rate Climbs for Older Americans*, WASH. POST, Jan. 23, 1996, at 5 (Health).
Caring involves a competition for limited health care funds, which requires that cost/benefit analyses and other economic tools be factored into the definition of the basic level of health care.\textsuperscript{21} Health care givers have a duty to provide a minimum level of basic care,\textsuperscript{22} perhaps a reasonable care standard. This duty is a legal one, ingrained in the principles of a physician's duty to his patient as a fiduciary acting in his patient's best interest.\textsuperscript{23} However, in defining the basic level of health care with which a person should be provided, the person's own duty to take care of his or her own health should not be forgotten. Each person has a duty to society to avoid engaging in unhealthy types of behavior, even if they do not affect anyone else. Although this hypothesis seemingly is at odds with philosophers who promote the basic principles of liberty, such as John Stuart Mill, further analysis reveals a unique congruence between them. Indeed, as espoused by Mill, the theory of liberty asserts that the individual belongs to himself and is subject to social control only for the purpose of preventing him from harming others.\textsuperscript{24} Taken further, however, one could state that

\begin{itemize}
\item \textsuperscript{21} Callahan, supra note 14, at 9-10. The State of Oregon reformed its Medicaid program by establishing its own system of priorities based on costs and available funding. See generally W. John Thomas, The Oregon Medicaid Proposal: Ethical Paralysis, Tragic Democracy, and the Fate of a Utilitarian Health Care Program, 72 OR. L. REV. 49 (1993).
\item \textsuperscript{22} In an effort to promote this general doctrine, Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA), Section 1395dd, as part of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). Pub. L. No. 97-272, 100 Stat. 82 (1986) (codified at 42 U.S.C. § 1395dd). This provision is designed to prevent "patient-dumping," a hospital practice of transferring or refusing to treat patients who are indigent or uninsured. See Daniel N. Rosenstein, Emergency Stabilization for a Wounded COBRA, 9 ISSUES L. & MED. 255, 255 (1993). COBRA was designed to regulate, not prevent, hospital transfer of patients who either appear at hospital emergency rooms or arrive at hospitals with emergency conditions. Rosenstein, supra, at 262. Courts, however, have expanded the application of COBRA to "any and all patients." See Cleland v. Bronson Health Care Group, 917 F.2d 266, 269-70 (6th Cir. 1990); see also Burrows v. Turner Memorial Hosp. Inc., 762 F. Supp. 840, 842-43 (W.D. Ark. 1991) (holding that EMTALA applies to all persons); Delany v. Cade, 756 F. Supp. 1476, 1485-86 (D. Kan. 1991) (adopting the reasoning of Cleland); Deberry v. Sherman Hosp. Ass'n, 741 F. Supp. 1302, 1306 (N.D. Ill. 1990) (holding that indigence or the inability to pay is not a prerequisite to COBRA coverage). Thus, given this expansive reading by the courts of COBRA's application, it is perhaps possible to formulate an argument in favor of applying COBRA to the principle of age-based health care rationing discussed infra part II.C. in this article.
\item \textsuperscript{23} See Maxwell J. Mehlman, The Patient-Physician Relationship in an Era of Scarce Resources: Is There a Duty to Treat?, 25 CONN. L. REV. 349, 361-67 (1993). At common law, a physician owes a patient a duty to provide reasonable care, and if this duty is breached by failing to provide a patient with the care that would be provided by a reasonable physician under the same circumstances, the physician may be liable for malpractice and other sanctions. Id.
\item \textsuperscript{24} See THE HISTORY OF POLITICAL PHILOSOPHY 797-98 (Leo Strauss & Joseph Cropsey eds., 1987). It should be noted that the theory of liberty by John Stuart Mill was not intended to be applied to any collection of individuals but only to a mature body of citizens with an educated sense of public responsibility. Id. at 798.
\end{itemize}
society is the sovereign over acts of the individual that impinge upon others.\textsuperscript{25} Given the finite nature of health care resources, the effort to provide everyone with a basic level of health care demands inherently that the individual practice self-restraint (one of Mill's principle conditions of liberty) and take preventive measures in caring for his own health. Once beyond this duty, the most rudimentary definition of basic health care remains the level of care that makes a person healthy and happy.\textsuperscript{26}

B. The Standard of Care Provided to the Elderly

Despite the predilection of society for allocating scarce health care resources to the aged, modern medicine appears to be biased against elderly citizens.\textsuperscript{27} The medical choices available to the elderly generally are fewer in number and the wishes of others often take precedence over their own.\textsuperscript{28} All too commonly, physicians fail to diagnose in the old and infirm medical ailments that are quickly identified in younger patients.\textsuperscript{29} Thus, incidents of inadequate health care delivery to the elderly are pervasive. Both diagnostically and from standards of treatment, more and more individuals upon reaching the age of sixty-five are routinely neglected or under treated by primary care physicians.\textsuperscript{30} Older people continuously are not provided with proper screening tests and are not prescribed needed medication. The neglect suffered by the elderly runs the gamut from failing to encourage women over sixty-five years of age to get regular mammograms to failing to encourage elderly men to get cholesterol and prostate cancer examinations, even though statistics show eighty percent of all fatal heart attacks and sixty percent of all cancer deaths strike those who are sixty-five or older.\textsuperscript{31}

Furthermore, elderly patients are often excluded from surgery on the

\textsuperscript{25}. \textit{Id.} at 798. According to Mill, the individual is the sovereign over himself, and society is not to exert any control over the thoughts of the individual, which are a part of himself. \textit{Id.}
\textsuperscript{26}. \textit{See Callahan, supra} note 14, at 10-12. \textit{See generally Smith, supra} note 5, at ch. 2.
\textsuperscript{27}. Indeed, elderly persons are frequently and often unfairly characterized by their susceptibility to illness and impaired physical, mental, and social functioning. \textit{See} Bernard M. Dickens, \textit{Medico-Legal Issues Concerning the Elderly — An Overview, in An Aging World} 487 (John M. Eekelaar & David Pearl eds., 1989).
\textsuperscript{28}. Terrie T. Wetle, \textit{Ethical Aspects of Decision Making for and with the Elderly, in Legal and Ethical Aspects, supra} note 5, at 258, 259. This concept is further evidenced by the paucity of personal autonomy surrounding medical treatment for elderly patients. Physicians may not fully disclose the purpose or risks of diagnostic procedures or may involve other members of an elderly patients family without consent. In addition, the care provider may choose to simply ignore the expressed wishes of the elderly patient about treatment, placement, involuntary hospitalization, or institutionalization. \textit{Id.} at 259.
\textsuperscript{30}. \textit{Id.; see Angier, supra} note 4, at E1.
\textsuperscript{31}. Podolsky & Silberner, \textit{supra} note 29, at 72-73.
premature assumption that their recovery chances are slim.  

Old and infirm patients suffering from cancer and other non-treatable illnesses are all too often dismissed. The classic attitude is illustrated by a typical physician’s comment, such as, “At his age, what does he expect?” A study conducted by the University of Wisconsin Comprehensive Cancer Center found that patients over the age of seventy-five were one-third as likely to be offered radiation and chemotherapy as were younger patients. As another example, while depression in the elderly is readily diagnosed, in 1991 the National Institute of Mental Health estimated that up to fifteen percent of older Americans suffer from depression yet over sixty percent of them receive inadequate therapy for this depression.

Interestingly, recent medical studies show overtreatment in some areas of health care to be another serious problem for the elderly, especially for certain surgical procedures. Excesses were revealed in the widespread use of coronary angiographies, carotid endarterectomies, upper-GI endoscopies, and coronary bypasses. In addition, inappropriate drug prescriptions are a concern.

A possible explanation for inadequate treatment or overtreatment of the elderly is the pervasiveness of paternalism in today’s society. It stems from society’s desire to protect its older citizens, yet oftentimes leads to the exclusion of the elderly from the decisionmaking process or to a type of dependency termed “learned helplessness.” This paternalistic approach is often taken with older patients even when their decisionmaking capabilities are hardly compromised. It perpetuates ageism, which assumes that old age automatically leads to incompetence.

32. Id. at 72.
33. Id.
34. Id. at 74.
35. Id. at 75. Even more alarming is the fact that doctors are able to diagnose depression among the elderly, however, they often are uncomfortable in treating it. Id.; see also Stanley Jacobsen, Overselling Depression to the Old Folks, ATLANTIC MONTHLY, Apr., 1995, at 46.
36. Podolsky & Silberner, supra note 29, at 76 (noting that 17% of the x-rays performed have been judged excessive. Coronary angiographies are x-rays of the blood vessels that nourish the heart.).
37. Id. (noting that one-third of the operations performed may have been questionable. Carotid endarterectomies are cholesterol clearing operations on blood vessels in the neck.).
38. Id. (noting that of all that were performed, 17% were inappropriate. Upper-GI endoscopies are visual inspections of the gastrointestinal tract.).
39. Id.
40. See Wetle, supra note 28, at 260. Paternalism fosters a decision-making process that does not necessarily include all of the relevant information. The missing information could be the most important in that it may address the individuals fears, desires, expectations, or other important factors. Id.
41. Id. at 259. In comparison, we as a society automatically assume that younger adults are competent to participate in the decision making process, unless considerable evidence to the contrary exists. Id. See generally Edmund D. Pellegrino, Patient and Physici
HEALTH CARE RATIONING

III. LIMITATIONS ON ELDERLY ACCESS TO MEDICAL CARE

Health is not an absolute condition but is assessed in reference to age and other factors. Therefore, a relative scale is necessary to determine whether an elderly person's right to health care is being satisfied. Today, the elderly are increasingly affected by the growing need to regulate health care delivery. Since 1900, those over the age of eighty-five years have become twenty-one times as numerous in society, with an eightfold increase in the number of people over the age of sixty-five. Given the need to curb rising health care costs, particularly the expenses related to caring for older individuals, and to improve access to health care, society has effectuated two methods of governing the distribution of limited health care resources: allocation and rationing.

A. Health Care Allocation

Allocation of health care resources involves a societal determination of what resources should be devoted to a particular program. The allocation process is typically performed on a "macro" level, with allocation decisions often only affecting statistical lives, that is, the statistical determination of various life and death rates arrived at based on the evaluation and computation of numerous factors. In contrast to the identifiable lives often affected by health care rationing, statistical lives affected by allocation decisions are much more readily sacrificed.

42. See Dickens, supra note 27, at 487.
44. David C. Hadorn & Robert H. Brook, The Health Care Resource Allocation Debate; Defining Our Terms, 266 JAMA 3328, 3328-31 (1991); see sources cited supra note 5 and accompanying text. Indicative of the rising costs of medical care for the elderly, Medicare expenditures increased at an average rate of 11.8% between 1980 and 1990. See Castro, supra note 5, at 34-35; OFFICE OF MGMT. & BUDGET OF THE UNITED STATES GOVERNMENT: FISCAL YEAR 1992, H.R. DOC. NO. 3, 102d Cong., 1st Sess. pt. 7, at 43-44 (1991); see also BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 632 (2d ed. 1991). The distribution of health care resources are, in turn, regulated primarily through the marketplace for medical services. Typically, the market moves resources to uses that are valued most and to persons who most value the resources. Id. at 633.
45. FURROW, supra note 44, at 633. Generally, allocation decisions also affect rationing decisions in that greater resource allocation to specific purposes ultimately leads to fewer difficult rationing decisions. Id.
46. See id. An example of a statistical life is the one life in fifty that will be lost in a year because the government fails to pursue a particular mine-safety regulation. Id.
47. Id.
A common means of deciding health care allocation is through political process.\(^4\) Government decisions pertaining to health care spending and regulation typically involve allocation determinations. For example, the Medicare and Medicaid programs allocate resources for numerous purposes.\(^5\) Hospitals, too, regularly make allocation decisions when determining the quantity and type of resources to have available.\(^6\) Their actions, in turn, directly impact upon physicians who subsequently also become health care allocators.

Whether government or society has a duty toward those affected by such allocation decisions is the subject of much debate. It has been argued that “the government [has] a duty, based on our collective social obligation, to help people live out a natural life span.”\(^7\) On the other hand, without a limit on investments in health care for the elderly, younger generations will suffer from inadequate available health care resources.\(^8\) Others argue that individuals should support health care plans that allocate fewer resources to health care in old age in exchange for more comprehensive health care earlier on in life.\(^9\)

**B. Health Care Rationing**

In broad terms, rationing commonly refers to the equitable division of scarce items by limiting the amount to which individuals are entitled.\(^10\)
Rationing of medical care is more narrowly defined as the deliberate denial of treatment to some individuals who might benefit from it. Within the health care arena today there exist largely two types of medical services that are currently scarce relative to demand: organs for transplantation and, on a less consistent basis, beds in intensive care units.

Rationing in the traditional sense connotes fairness and is perhaps best depicted by the organ transplant process. Patients needing organ transplants will, ideally, wait in turn to receive their “ration” from available organs, regardless of their wealth or insurance status. This process would allow for the equitable distribution of a physically scarce resource among individuals previously identified as being in need. In reality, rationing, which is pervasive throughout the health care industry, no longer represents the deliberate, equitable sharing of a scarce commodity. Rather, rationing has come to represent discrimination in access to health care services on the basis of socioeconomic status.

C. Justifications For Age-Based Health Care Rationing

Proponents of rationing believe that anything short of rationing will not prevent a looming economic catastrophe the health care system, arguing that rationing is the only way of managing unbridled patient demands, an aging population, and rapid advances in medical technology. They argue that
an explicit system of rationing health care services must be implemented to avert a national disaster. This argument, however, is founded on more than economic considerations.

Older persons seem particularly susceptible to designation for rationing efforts. Commentators have argued that an integral part of a rationing system is to ration care among the elderly, thereby restricting expensive, high-technology, life-sustaining care for those who have reached a certain age. Implicit in this argument is the principle that elderly health care represents an investment of scarce resources with limited returns. In addition, this argument reflects an intuitive conclusion that an older person has less chance of achieving a successful clinical outcome. The assumption is therefore made that vast resources are spent on care for dying elderly. Thus, it is assumed, or it is thus assessed, that vast resources are spent consequently on care for the dying elderly. This is an assumption bolstered by empirical evidence. In further support of age-based rationing, proponents have proffered a gamut of benefits to society, including productivity, equality, natural life span, intergenerational justice, and medical.

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60. Smith & Rother, *supra* note 59, at 1849.


62. Smith & Rother, *supra* note 59, at 1849-50. By limited returns, commentators mean that intensive and aggressive treatment often serves only to prolong the inevitable agony of death. Id. at 1850. Their argument is developed by stating that since no significant benefit is derived from providing the elderly with untold medical opportunities, they should not be made available. Since old age inevitably brings with it sickness and ill health, measures designed to abate this deterioration would not enhance significantly the quality of life. Accordingly, extending life under these circumstances does not confer a substantial benefit and should not be undertaken. Although it could be argued that age-based rationing reflects age bias, the truth is indisputable that “the chances of benefiting from life-extending measures decrease as people age.” Wicclair, *supra* note 54, at 85. See generally George P. Smith, *II, Death Be Not Proud: Medical, Ethical and Legal Dilemmas in Resource Allocations,* 3 J. CONTEMP. HEALTH L. & POL’Y 47 (1987).


64. Smith & Rother, *supra* note 59, at 1849-50; see James Lubitz & Ronald Prihoda, *The Use and Costs of Medicine Services in the Last 2 Years of Life,* 5 HEALTH CARE FINANCING REV. 117, 117-31 (1984). Based on 1978 data, the study noted that the less than 6% of Medicare beneficiaries who died in that year accounted for approximately 28% of Medicare expenditures. Id. at 119. But see Angier, *supra* note 4, at E1 (stating that the “super old” die more quickly and thus less expensively than the “younger old”). See generally Mary Beth Hammel et al., *Seriously Ill Hospitalized Adults: Do We Spend Less on Older Patients?*, 44 J. AM. GERIATRICS SOC. 1043 (1996).

Withholding costly medical treatment for the elderly has been justified on the basis of waning productivity in the later years of life. It is an argument centered on an investment return theory, suggesting that the dollars spent on elderly health care may better benefit society if invested in patients with greater potential.  

Coupled with the greater investment return argument is the suggestion that individuals have the right to live to the same approximate productive age as others. Health care services for the elderly should be curtailed in order to facilitate this outcome. By limiting health care for the elderly, services can be provided to allow all, to the extent possible, to reach a certain age.

Age-based health care rationing also has been justified on the basis of intergenerational justice and natural life span theories. The view articulated is that health care costs for the elderly invariably deprive younger generations of access to adequate health care, and thereby limit their exposure to other life experiences. Under this theory, the elderly should recognize that their own welfare was the result of another generation’s hard work and should therefore deem their health care needs as inferior to those of the younger generation.

Finally, the assertion is made that physical conditions, such as advanced age, common among elderly patients, preclude them from experiencing the benefits that certain medical treatments have to offer. This position relies upon empirical evidence that advanced age reduces the chance of positive medical results.
D. Considerations Weighing Against Age-Based Rationing

The argument is often made that health care services should not be rationed at all, particularly not on the basis of age. Proposals in support of age-based rationing do not generally advocate the withholding of all medical treatment from older persons. Rather, such proposals suggest that expensive, aggressive care should be withheld from elderly patients.\textsuperscript{72} According to one study, withholding all care for high-cost Medicare decedents would have resulted in a $2.8 billion saving in 1987.\textsuperscript{73} This sum is deceptively large, however, given that health care expenditures have reached over one-half trillion dollars.\textsuperscript{74} While withholding high-cost health care from older patients who are seriously ill may save money, this must be balanced against the loss of many lives.

A theme that consistently reappears in analyses of age-based rationing is the value of an elderly person’s life. Some make the argument that excluding older persons from expensive medical treatment may allow society to realize a greater return for those invested dollars.\textsuperscript{75} Moreover, commentators argue that limitations on health care to the elderly will allow for greater equality in the number of life years attained.\textsuperscript{76} This position affixes a demeaning, monetary value to a human life. Regulating access to medical care based on age runs against the egalitarian nature of our society and the principle that all human life is sacred and equally deserving of protection.\textsuperscript{77}

Another widely discussed justification for rationing life-sustaining health care for the elderly is the natural life span principle.\textsuperscript{78} This proposal attaches a normative average to valuating a person’s natural life span, calculated to be roughly around the late seventies or early eighties, after which a person “should receive only supportive and palliative care.”\textsuperscript{79} The goal of establishing an acceptable age after which health care should be rationed attempts to apply a homogeneous criterion to a heterogeneous

\textsuperscript{72} Smith & Rother, supra note 59, at 1850.
\textsuperscript{74} See \textit{id}.
\textsuperscript{75} See sources cited supra notes 66-68.
\textsuperscript{76} See \textit{Wicclair}, supra note 54, at 90; Callahan, supra note 69, at 30.
\textsuperscript{77} Smith & Rother, supra note 59, at 1853; see Kilner, supra note 66, at 90.
\textsuperscript{78} See sources cited supra note 69; \textit{see also} George P. Smith, II, \textit{The New Biology: Law, Ethics and Biotechnology} ch. 3 (1989).
\textsuperscript{79} Smith & Rother, supra note 59, at 1834 (citing \textit{Callahan}, supra note 19, at 76-78). See generally George P. Smith, II, \textit{All’s Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination}, 22 U.C. Davis L. Rev. 275 (1989).
society. The contributions made by elderly citizens to society vary widely and make it very difficult to value a human life strictly by age and natural life span.  

In addition, although it has been suggested that the elderly should give priority to the health care needs of younger generations, intergenerational equality is a two-way street. Although the work and contributions of the younger generation provide for much of the older generation’s welfare, it must not be forgotten that the sacrifices of the elderly created many of the resources, opportunities, and services that younger generations now enjoy.

The presumption that old age hinders the possibility of favorable medical outcomes may be statistically accurate but remains a highly undependable predictor of clinical-outcome. What must be considered is that older people generally are, as a population, physiologically and psychologically very different. As such, curtailing treatments pursuant to an arbitrary, age-based policy will not result in the most efficient use of medical resources. This age-biased policy of health care distribution fails to recognize individual human potential.

E. The Oregon Plan’s Impact Upon Health Care Rationing

In 1989, the Oregon legislature enacted a law calling for a ranking of health services from most effective and most valued to least effective and least valued. While other states have prioritized medical services that will not be funded if state resources fall short, Oregon’s plan goes beyond such an “elimination list” by ranking all services according to the benefit each provides to the patient.

80. Smith & Rother, supra note 59, at 1854-55.
81. Id. (citing Vernon L. Greene, Human Capitalism and Intergenerational Justice, 29 GERONTOLOGIST 723, 724 (1989)). Greene notes that if the elderly human capital investment is analyzed from an economic perspective, the return on their investment would be far from competitive. Id.
82. Id. at 1852 (citing Jahnigen & Binstock, supra note 73, at 26).
83. See id. at 1852-54. See generally George P. Smith, II, BIOETICS AND THE LAW: MEDICAL, SOCIO-LEGAL AND PHILOSOPHICAL DIRECTIONS FOR A BRAVE NEW WORLD ch. 2 (1993).
84. Thomas, supra note 21, at 49-50.
85. Id. at 96-97. For example, Alaska and Maine have adopted “elimination lists” that specify the order in which services will be eliminated should the state be unable to fund all services. Id. The Alaska Statute provides:

If the [Department of Health and Social Services] finds that the cost of medical assistance for all persons eligible under this chapter will exceed the amount allocated in the state budget for that assistance for the fiscal year, the department shall eliminate coverage for optional medical services and optionally eligible groups of individuals in [a specified order].

ALASKA STAT. § 47.07.035 (1992).
The Oregon plan comprised a final list of 709 condition-treatment pairs, compiled by the Oregon Health Services Committee. The list, for example, ranked medical therapy for bacterial pneumonia as the most important medical treatment and life-support for anencephalous as least important. The priority list was designed to be applied to all segments of the population, including the elderly. Given the Oregon plan’s broad and comprehensive coverage of medical treatments, benefits and funding for eligible persons are strictly regulated.

The controversial element of the Oregon plan stems from the authority vested in the legislature to address shortfalls in funding for medical treatment by eliminating services in the order of priority as established by the list of condition-treatment pairs. Consequently, eligible persons needing treatment for lower-end priority conditions will not be able to obtain these services through Medicaid. Although the Oregon plan does not directly impact the Medicare system because it is federally funded and federally administered, passage of the Oregon plan symbolizes a legitimization of health care rationing. The argument is made that it rations in a far more equitable manner than currently available alternatives. Suggestions of rationing health care are often met with animosity and claims of inequality. Nonetheless, the Oregon plan is an innovative step designed to provide some form of universal health care to the residents of Oregon.

IV. THE EQUALITY OF AGE-BASED HEALTH CARE ALLOCATION AND RATIONING

The theory of equal medical treatment implicitly supports the proposition that persons with similar health conditions receive roughly the same health

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86. The Oregon plan’s top ten priorities are as follows: (1) medical therapy for bacterial pneumonia; (2) medical therapy for tuberculosis; (3) medical and surgical treatment of peritonitis; (4) removal of a foreign body in the larynx, trachea, bronchus and esophagus; (5) appendectomy for appendicitis; (6) repair of a ruptured intestine; (7) hernia repair; (8) medical and other therapy for croup syndrome; (9) medical therapy for acute orbital cellulitis; and (10) surgery for ectopic pregnancy. Oregon Health Services Comm’n, Prioritization of Health Services, A Report to the Governor and Legislature, app. J (1991). See generally Paige R. Sipes-Metzler, Oregon Health Plan: Ration or Reason, 19 J. MED. & PHIL. 305 (1994).

87. See Thomas, supra note 21, at 103-04.

88. id. at 104. This list will inevitably grow or contract every two years, depending on the condition of the budget cycle in Oregon. Id.

89. Id. at 105. The preclusion for Medicaid services will include such conditions as lung transplants (number 607), medical treatment for traumatic brain injury (number 684), and viral hepatitis (number 597). Id. See generally Mark A. Hall, The Problems with Rule-Based Rationing, 19 J. MED. & PHIL. 315 (1994).

HEALTH CARE RATIONING

Given the reality of scarce medical resources, however, society is faced with the task of allocating the resources as equitably and efficiently as possible. Thus, the debate is no longer whether health care should be rationed, but rather, how to ration it equitably.

A. The Equal Opportunity Argument

Empirical studies indicate that, given the rate at which the number of elderly and their needs are increasing, no society has all the resources necessary to completely fulfill these needs. With age-based rationing, however, equal access to health care is ostensibly achieved since with the passage of time, individuals inevitably move through the various stages of life. Furthermore, the opportunity to live out one's life is understood to include such aspects as work, love, procreation, raising a family, and enjoying life with others. Most aged members of society have experienced these opportunities of life. Thus, age-based rationing does, in essence, provide elderly citizens with the same opportunities afforded to younger citizens.

Also bolstering age-based rationing is the empirically supported fact that ageism typically lasts for only one decade. Thus, the older person will have experienced the benefits of age-based rationing throughout their earlier years in life. Allocating resources to the elderly and extending old age is not likely to alter a person's earlier experiences in life, much less open up radically new opportunities not before available.

One age-based health rationing plan sets forth the goal of guaranteeing a minimally decent level of health care for all, while limiting the private demands of ailing elderly. Specifically, the plan proposes to cut off all but the most basic medical care at the age of eighty. This policy would be instituted through the Medicare/Medicaid system and would consistently refuse to fund intensive treatment beyond the established age limit. It is argued that such a plan is both decent and manageable, and that only through such an active plan can society avoid a serious crisis in health care costs.

91. See B.J. Soldo et al., Epilogue: Confronting the Age of Aging in Ethics of Health Policy for Elderly, 19 SOCIO-ECON. PLAN. SCI. 289, 290 (1985). In fact, there are very few societies that could satisfy, even minimally, the needs of the elderly without compromising other social goals benefitting both young and old, such as education, police protection, housing, and transportation. Id.
92. See Jecker, supra note 43, at 3013.
93. Id.
94. Id.
95. Id. at 3014.
96. CALLAHAN, supra note 20, at 32; see supra notes 59-77 and accompanying text for the pros and cons of aged-based rationing.
97. Russ, supra note 3, at 88-89 (citation omitted).
B. The Elderly Discrimination Argument

Age-based rationing of health care may serve as a further tool of discrimination against the elderly, and thereby excite tensions between the generations. In today's society, the aged face a number of reduced opportunities in many facets of life. Such discrimination, however, is not an officially sanctioned aspect of our culture. While not set forth explicitly, the Universal Declaration of Human Rights, adopted and proclaimed by the General Assembly of the United Nations Organization in 1948, provides implicitly for an obligation of nondiscrimination on the basis of age.\(^9\)

Furthermore, national or regional human rights provisions often go beyond international law in offering guarantees of nondiscrimination on the basis of age.\(^9\)

Promoting age-based rationing is detrimental to the elderly because it threatens the very security that should come with old age and indeed, devalues older people. It caters to a youth-oriented culture in which negative stereotyping based on age is prevalent.\(^10\) Age-based rationing carries the danger of signaling to society that the old are not as respected as the young. In addition, denial of life-extending treatment to the elderly may foster the trend of not giving equal respect to the elderly.\(^10\)

The determination of health care rationing hinges upon how life-extending care in old age is classified.\(^10\) Unequal access to basic goods and services promotes inequality and is demeaning to those who are thereby excluded.\(^10\) It is morally unacceptable to ration beneficial health care except in the most extreme of situations.\(^10\) Thus, medical treatment cannot ethically be denied to any predetermined segment of the population on the

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98. Specifically, the Declaration states: “Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.” G.A. Res. 216, U.N. Doc. A/810, at 71 (1948) (emphasis added).

99. See, e.g., CAN. CONST. (Constitutional Act, 1982) pt. I (Canadian Charter of Rights and Freedoms), § 15(1) (governing discrimination based on race, national or ethnic origin, color, religion, sex, age, or mental or physical disability).

100. Id.


102. CAN. CONST. (Constitutional Act, 1982) pt. I (Canadian Charter of Rights and Freedoms), § 15(1). An interesting analogy involves comparing the denial of life-extending care in old age to either the prohibition of using public funds to pay for fancy food and drink or to the withholding of public funding for basic services such as primary education or legal assistance. Id.

103. Id. Basic goods and services can be defined as primary education, police protection, legal aid, and the right to vote. Id.

104. See Smith & Rother, supra note 59, at 1856.
basis of age.\textsuperscript{105} Such a denial could, in essence, deny patients life itself.\textsuperscript{106} The major factor in determining the propriety of any medical treatment should be the patient’s condition, and not an artificial criterion such as age or status.\textsuperscript{107}

C. Who Should Decide?

The ultimate decision on the merits of age-based rationing and the provision of life-extending care is directly linked to society’s perception of health care for the elderly and society’s medical capabilities. This decision-making process inevitably introduces value considerations into policy formulations, specifically into the policy surrounding the allocation of expensive health care resources to the elderly. Allowing values to be a factor may ultimately hinder the resource-allocation planning process. Nevertheless, safeguarding the personal values of the elderly may require such a compromise.\textsuperscript{108}

Theoretically, the federalist system and the process of democratic decisionmaking should establish acceptable medical priorities and delineate societal values.\textsuperscript{109} Yet, the contemporary process of democratic decisionmaking assures neither an accurate nor an equitable formulation of health care policy.\textsuperscript{110} A more pragmatic response lies in the creation of a uniform national or community health policy developed with “a strategy for

\textsuperscript{105} See Russ, supra note 2, at 89. According to Russ, the only acceptable form of age-based denial of medical treatment would be in cases “when no further treatment is indicated and the patient is irreversibly engaged in the dying process.” Id.

An interesting four-year study of chronically ill adults 65 years of age and older, conducted in Boston, Chicago, and Los Angeles, found that patients who were both elderly and poor and were treated by health maintenance organizations had worse physical health outcomes than those treated by fee-for-service physicians. John E. Ware et al., \textit{Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems: Results from the Medical Outcomes Study}, 276 JAMA 1039, 1039 (1996).

\textsuperscript{106} Russ, supra note 2, at 89.

\textsuperscript{107} Id.; see Smith \& Rother, supra note 59, at 1856-57.


\textsuperscript{109} The federalist system in the United States was designed, in part, to allow states and their citizens to act as “laboratories of innovation.” Robinson, supra note 90, at 986. In this way, states could implement novel social and economic programs without risk to the whole country. Id. (citing New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting)). A striking example of this power is the Oregon Health Plan, discussed supra part III.E.

\textsuperscript{110} See Soldo, supra note 91, at 292. The belief that the U.S. political process is able to generate a consensus regarding such a policy issue is quixotic. Political debate is increasingly shaped by special interest groups and constituency pressures. Although the debate over the virtues of our political system evokes varying positions, the fact remains that political debate as it exists in our society impedes the emergence of a recognizable value consensus. See id.
controlling, regulating and optimizing the social uses of its limited [medical]
knowledge and resources." 111 This policy needs to factor in all relevant
emerging societal trends, including the growth of the aging population112
and the dwindling number of nonelderly adults who have heretofore
traditionally supported both young and old dependents.113 Further research
into causes of old-age diseases, continued development of outcomes research,
and promotion of widespread execution of advance directives are all useful
means by which limited health care resources can be maximized.114 In
addition, there needs to be some complement to the legislative process via an
effective public forum in which health care matters of concern can be
publicly debated.

Formulating a national policy on the health care requirements of the
aging presents inevitable value conflicts. There exists a common perception
that the transfer of social resources essentially polarizes the younger and
older generations.115 Nevertheless, such an intergenerational clashing of
values must not be viewed as an obstacle. Rather, the rational resolution of
competing health care policy considerations requires that conflicting values
be scrutinized and through the use of a standard of reasonable use and
allocation, be interlinked with one another. It must be remembered that
values generally serve as self-justifying ordering and selecting principles
unless they are critically and impartially evaluated.116 Thus, regardless of
how objective the approach of society toward constructing an equitable
national policy on health care allocation to the elderly, competing value
concerns must be addressed in an orderly, critical, and reasonable way.117
The tool allowing society to undertake such a critical evaluation is ethics.118

Ethics is an unparalleled regulator of value selection and is essential to
the formulation of a national, elderly health care policy. The American

111. Id. at 289.
112. According to studies, the population growth of those 65 years of age and older is
predicted to peak in about 2020. Id.
113. Id.
114. Smith & Rother, supra note 59, at 1857.
115. Soldo, supra note 91, at 289. Indicative of this conflict is the financial solvency of
the Social Security system, which when operating as envisioned, serves as a structural means
of transferring financial resources from the younger, working age population to the older,
retired population. Id.
116. Id. at 290.
117. Id. Society must categorize values in a hierarchical manner, recognizing that such
rankings may shift depending on the nature of the value. Moreover, there are numerous
values that may predominate in any given situation, including social, cultural, political, ethnic,
fiscal, economic, personal, and religious values. Id.
118. Id. The progression can be viewed as such: computer simulations, strategic models,
and empirical studies all affect one's values. Ethics is the science of morals and serves as the
"modulator of a selective membrane that regulates the way values structure policy strategies."
Id.
Medical Association's Principle of Ethics, for instance, states clearly that notwithstanding the societal interest in containing health care costs, "concern for the care the patient receives will be the physician's first consideration." The weighing of the ethical aspects of medical decision-making for the elderly would indicate how aggressive treatments or intervention should be in prolonging a life otherwise viewed as having limited potential.

Health care considerations for the elderly often involve disabled, ill, poor, and lonely persons. Moreover, members of society tend to place different values on each of these groups and, consequently, no collective societal obligation to such groups emerges. A continuous process that allows for the examination and reexamination of health care costs and benefits, coupled with an evolving assessment of value judgments and ethical concerns, would be a move towards establishing an equitable elderly health care allocation program. Such a move, if combined with a firm grasp of the formal discipline of ethics, allowing for the critical and rational objective examination of competing values will result in an acceptable long-term solution towards elderly health care allocation. The outcome should be a viable program fostering a degree of social maturity and limiting the wide oscillations of public policy.

V. CONCLUSION

As society confronts the challenging task of allocating scarce health care resources to the elderly, the framework for this process is quite clear. There needs to be comprehensive health care reform, including reform directed at the practice of medicine and the way services are reimbursed, to maximize the availability of limited health care resources. The formulation of an equitable elderly health care policy is fundamentally a balancing test.

120. See Wete, supra note 28, at 265-66.
121. See generally id.
122. Furthermore, given the limited health care resources available, "unfair" choices are often made that disadvantageously impact one group or another. Id. at 266.
123. Soldo, supra note 91, at 292. Additional factors to be considered include changes in resource competition, expenditures, and values or ethical decisions. Id.
124. Smith & Rother, supra note 59, at 1857. Medicare costs, for example, could be reduced by limiting payments under the program in the last two years of life and through greater use of advance directives, hospice care, and less aggressive interventions (e.g., orders not to resuscitate). Another suggestion for reform is to restructure health care financing and thereby encourage the use of long-term and primary care services, which would allow for functional independence. This would require the integration of Medicare financing for acute care with financing for long-term care. Andrew M. Kramer, M.D., Health Care for Elderly Persons — Myths and Realities, 332 N. ENG. J. MED. 1027, 1028 (1995).
weighing social justice against biological needs. In other words, the competing principles of health care distribution to the elderly center around equity versus need.

Ultimately, in order to confront the issue of health care rationing for the elderly, society must effectively integrate the disciplines of moral and ethical reasoning with the quantitative formulations of needs and resources. Such an effort, supported by an abundance of public debate and discussion, will result in an equitable policy on elderly health care rationing with long-term viability. Until such a point, however, the greatest danger to avoid is the daily perpetuation of nondecisions regarding health care treatment for the elderly. Such decisions all too frequently result in the nontreatment of elderly patients and institutional residents because of an inability to effectively assess the equitable and efficient allocation of scarce health care resources.

The real moral question raised from this debate is not whether too much treatment or too little is offered. Rather, "it is how to optimize the appropriateness of the treatment"; therein lies the moral obligation of health care. However difficult or tragic the allocation decision is to make, taking no action is perhaps the most pernicious conduct of all. Society must

125. Soldo, supra note 91, at 290. The specific factors to be weighed include moral, social, cultural, and spiritual values, along with economic imperatives. Id. See generally GEORGE J. ANNAS, STANDARD OF CARE: THE LAW OF AMERICAN BIOETHICS ch. 16 (1993).
126. Soldo, supra note 91, at 290. Even after having identified the two ends of the health care distribution spectrum, the undefined area between these points remains. Specifically, society must determine whether "equity" truly requires equal treatment for all those needing health care services, regardless of age or socioeconomic status. Furthermore, the type of "need" must be clarified, that is, whether the need is fiscal, medical, sociopsychological, or simply personal preference. Id.
127. Id. at 293; see SMITH, supra note 5, at ch. 4.
128. Soldo, supra note 91, at 293.
130. According to a recent survey of actions taken by critical care nurses in their work, it was found that in nearly one in five intensive care units, these nurses reported having deliberately hastened a patient's death. David A. Asch, The Role of Critical Care Nurses in Euthanasia and Assisted Suicide, 334 N. ENG. J. MED. 1374 (1996).
A five-year hospital study of more than 4300 seriously ill adults treated at five major medical centers reported, rather predictably, that seriously ill elderly patients 80 years of age or older underwent surgery about half as often as those patients under 50 years of age with the same illness, and that the hospital bills of the elderly patients averaged about $7000 less. Patients in the study had at least one of nine illnesses (e.g., congestive heart failure, advanced colon cancer, lung cancer) and had an average life expectancy of six months. Hammel et al., supra note 64, at 1043.
realize that "aging is not a disease, [but] an inherent part of human life."¹³²

Would it be absurd then to suppose that this perfection of the human species might be capable of indefinite progress; that the day will come when death will be due only to extraordinary accidents or to the decay of the vital forces, and that ultimately, the average span between birth and decay will have no assignable value? Certainly man will not become immortal, but will not the interval between the first breath that he draws and the time when in the natural course of events, without disease or accident, he expires, increase indefinitely?¹³³

¹³² Christine K. Cassel, Ethical Aspects of Decision Making for and with the Elderly, in LEGAL AND ETHICAL ASPECTS, supra note 5, at 3; see SMITH, supra note 5, at 134. See generally RICHARD A. POSNER, AGING AND OLD AGE (1995).
