

ALLOCATION AND AGEISM IN AOTEAROA

An exploration of the ethical justification for age-based healthcare rationing

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For Grandma

You truly understand the value of a human life

ABSTRACT

New Zealand's population, like many first world countries, is 'ageing'. This will place our healthcare system under increasing and changing pressures, as there will be a greater proportion of older people in our population who have particular health needs and generally require greater levels of care over longer periods. These projected changes have resulted in calls to ration healthcare resources to the elderly. This is driven in part by concerns that the elderly will consume resources at the expense of other generations. Such proposals have been met with staunch criticism, most of which focuses on the idea that age-based allocation devalues those discriminated against, *viz.* the elderly. In this thesis I argue that this criticism can theoretically be overcome if the principles of age prioritisation are applied consistently over the lifetime of members of society, so that everyone is equally affected. I then introduce Norman Daniels' 'Prudential Lifespan Account', which provides a moral basis from which such principles can be derived. This shows us that as a society we should protect the 'normal range of opportunity' available to citizens. This creates a need for resources to be distributed fairly between generations in order to ensure that each is given the best chance possible of having the normal range of opportunity. Under this theory, certain forms of age-based allocation can be justified. I go on to outline Daniel Callahan's view of the nature of mortality and end-of-life care, which incorporates Daniels' Prudential Lifespan Account. This provides a helpful framework for reflecting on our collective response to ageing and dying, which will place certain limits on the amount spent on care for the elderly. However, these limits will not ultimately address the challenges our healthcare sector is currently facing due to the ageing population. With this in mind, I consider whether a straightforward cut-off for healthcare allocation is ethically justifiable. I argue that it cannot because it contradicts the basic principles of justice underpinning Norman Daniels' theory, and so lacks an adequate moral foundation. Some other responses must be taken in order to ensure that members of our society receive their share of opportunity. In the final chapter I outline some possible strategies that are consistent with the ideals put forward by both Daniels and Callahan.

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CHAPTER 1: HEALTHCARE ALLOCATION AND THE AGEING POPULATION

Forty-five years ago, The Beatles asked, ‘will you still need me, will you still feed me, when I’m sixty-four?’ These questions are now looming large in countries with an ageing population, such as New Zealand. Healthcare has radically changed in many countries over the past century, particularly because modern medical technology has revolutionized the possibilities of medical care, and because our attitudes to an experience of illness have been significantly altered. There now exists, for the majority of conditions, a medical intervention to fight the underlying disease or failing that, for symptom control. As a result of this, people in countries with a socialized health system have an expectation that if they develop a health condition they will be able to receive treatment through the public system that will improve their quality of life. If the Beatles had written their song today it might very well have been ‘I expect you to need me, and I expect you to feed me when I’m sixty-four’.

These revolutions in medical technology and subsequent increased expectations on the health sector have occurred alongside an increasing life expectancy in New Zealand. The average age of death has risen from 62 years for females and 60 years for males in 1950 to 82 years for females and 78 for males in 2007.¹ In parallel with this, the advent of reliable contraception has seen the birth rate steadily decline from 4.2 children per couple in 1962 to 2.1 currently.² The cumulative result of these demographic changes is an increased proportion of elderly in our community. It is for this reason that people often refer to New Zealand’s population as ‘ageing’: there has been an increase in the proportion of elderly citizens in relation to younger citizens. Accordingly, the median age of the population has risen dramatically through the years³ and it has been predicted that thirty years from now 25% of our population will

¹ Statistics New Zealand, "New Zealand Life Tables 2005-2007," <http://www.stats.govt.nz/>.

² Statistics New Zealand, "Fertility Rates," <http://www.stats.govt.nz/>.

³ The median of the New Zealand population has risen for both males and females since 1970. The median age was 24.8 years for males and 26.4 years for females in 1970 and rose to 35.5 years for

be over the age of 65 (our current retirement age), compared to only 9% in 1950. This will only add to demands on the healthcare sector since it will be required to support a far greater number of elderly persons, who as a group generally require greater levels of care over longer periods. Predictions made regarding our ageing population have shown that by 2028 almost 50% of health spending will be on people aged sixty and over.⁴ The New Zealand Treasury has predicted that as these changes continue, Ministry of Health spending will increase its current share of national income from 9% in 2005 to over 13% by 2050.⁵ There is already a deficit in healthcare service provision in New Zealand, in that there are not enough healthcare professionals, equipment or money to see that everyone gets the care they need.⁶ This has resulted in calls both nationally and internationally for discussion of public healthcare funding and allocation, particularly on the matter of rationing healthcare resources to the elderly.⁷ This thesis explores whether age-based healthcare allocation can be justified.⁸

1.1 Overt healthcare rationing in New Zealand

Rationing is already occurring in New Zealand and it is becoming an acknowledged component of contemporary health policy. It occurs at three levels. Firstly, the amount of money directed into the public health sector must be agreed upon, along with the types of treatments that will be funded. This is referred to as macro-allocation. Such decisions are made at a governmental level by representatives and policy makers with a range of political, ethical and pragmatic concerns in view.

males and 37.7 years for females in 2010. In: Statistics New Zealand, "Mean, median, and modal age of the population, 1970–2010," <http://www.stats.govt.nz>.

⁴ G. Morgan and G. Simmons, *Health Cheque: The Truth We Should All Know About New Zealand's Public Health System* (Phantom House Publishing, 2009). p. 169

⁵ Ibid.

⁶ Rodger Styles, the CEO of the New Zealand Health Funds Association discussed these issues on National Radio in January 2013, saying that 'there are huge funding pressures on the government. They are borrowing heavily to maintain their current level of service...we need to have public debate on these topics so that we can find solutions so we can avoid a situation where cuts are forced upon us.' T Graham and C Cherry, "Health Leaders Call for Public Input into Funding Options," in *Summer Report* (Radio New Zealand, 2013).

⁷ See, for example; internationally D Callahan, "Must we ration health care for the elderly?," *Journal of Law, Medicine and Ethics* 40, no. 1 (2012)., or nationally J. Yap and L. Celi, "Elderly access to medical care: should age be a factor in deciding management?," *The New Zealand Medical Journal* 120, no. 1266 (2007).

⁸ Healthcare rationing has been defined as 'the conscious denial of potentially beneficial medical interventions to particular patients for the purpose of conserving and redirecting scarce resources.' In: D. Kapp and B. Marshall, "De Facto Healthcare Rationing By Age: The Law Has No Remedy," *Journal of Legal Medicine* 19, no. 3 (1988). p. 323

Secondly, there are meso-allocation decisions, which occur at the level of the District Health Board. These are primarily concerned with which particular services or treatments will be funded. Finally, there are micro-allocation decisions, which involve selecting who will receive treatments. There are a number of ways micro-allocation decisions are currently made in New Zealand. I will briefly outline the two most commonly used methods.

For elective procedures⁹ New Zealand has developed scoring tools named CPAC (Clinical Priority Assessment Criteria). These provide a measure of a patient's need relative to others, and thereby enable clinicians to determine which patients should be treated first. For some treatments, the clinical unit will decide on a threshold score, and a patient is booked for the relevant procedure once they reach that score.¹⁰ These scoring tools provide a basis on which patients can be denied care, as there is a clear indication that there are others who need it more (i.e. persons with a higher score). However, CPACs are not failsafe and there are a number of problems associated with them.¹¹

Another method of comparing people and treatments when prioritising healthcare resources is through a calculation of the QALYs (Quality Adjusted Life Years) expected following treatment. The QALY attempts to combine the quality and length of life expected to follow an intervention, in order to give a measure of the value of a treatment. This measure is often used in meso-allocation decisions when comparing different treatments. They require the reduction of all medical outcomes to something commensurable – 'quality of life' – so that dissimilar interventions can be compared

⁹ Elective surgery refers to surgery that can be scheduled in advance because it does not involve a medical emergency. Elective surgery includes surgeries that are medically necessary, (e.g. inguinal hernia repair or a mastectomy for breast cancer) and also surgeries that are not medically necessary (e.g. cosmetic surgery). In this discussion I use the term elective surgery to refer to surgeries that are medically necessary.

¹⁰ For example, a couple who wishes to receive publicly funded fertility treatment will be asked a number of questions by their healthcare professional in order to determine their CPAC score. The fertility combines points from a number of different criteria. These include objective criteria that relate to the chance of pregnancy (age, FSH level and smoking) along with social criteria (previous children, previous voluntary sterilization and duration of infertility). If a couple scores over 65 points they are eligible for publicly funded treatment, if they score under 65 points they are not eligible for publicly funded treatment.

¹¹ Morgan and Simmons, *Health Cheque: The Truth We Should All Know About New Zealand's Public Health System*. p. 169

using the same scale. It is also used in micro-allocation decisions to allow a comparison of different patients where a simple calculation can be done in order to determine the number of QALYs expected for each individual as a result of the intervention. It is likely that priority will be given to those patients with the greatest expected number of QALYs following treatment. This also allows a calculation of the cost per QALY of a given treatment and allows healthcare professionals to clearly see which treatment will give the greatest number of QALYs per dollar spent.¹²

Though a calculation of QALYs may seem at a certain level to be fair, the notion of a QALY is based on the assumption that there is a reasonable way in which the length of life can be traded off by the quality of that life.¹³ For example, one QALY represents one year of life in perfect health whereas half a QALY would represent one year of life in less than perfect health. These numbers reflect a sense of how people in society currently evaluate different healthcare states. Such methods have been subject to a number of criticisms. One criticism is that the use of QALYs seems to penalize people who have a short life expectancy due to a poor prognosis. This is because someone with a higher QALY score (and most likely a better prognosis) is likely to receive a treatment over someone with a lower QALY score (and perhaps a worse prognosis). It would seem that in some cases those individuals with the worst prognosis are assigned a lower priority than individuals with a better prognosis and therefore a longer life expectancy following treatment. Critics of the QALY system also claim that it discriminates against elderly people.¹⁴ One such critic has asked the following crucial question: 'say two people needed lifesaving treatment and there were resources to treat only one...If QALYs were used the younger patient would inevitably and always get the treatment, but is that fair?'¹⁵ If this is not fair, then it seems there must be something inherently unfair about the QALY system.

¹² M. Lockwood, "Quality of Life and Resource Allocation," in *Quality of Life and Resource Allocation*, ed. H Kuhse and P Singer (USA: Blackwell Publishing, 2006). p. 453

¹³ Ibid. p. 453

¹⁴ J. Harris, "Deciding Between Patients," in *Companion to Bioethics*, ed. H Kuhse and P Singer (UK: Wiley-Blackwell Publishers, 2012). p. 338

¹⁵ Lockwood, "Quality of Life and Resource Allocation." p. 454

While the use of CPACs and QALYs offer guidance in some situations, they are not without problems and there are still many situations where clinicians are without clear guidelines and transparent rules for making allocation decisions. They are therefore left to decide who to treat and how to use their health budget in the most just and ethical way possible. In such cases the patient is vulnerable to the personal biases of the health practitioner.

1.2 Covert healthcare rationing in New Zealand

Rationing through the CPAC and QALY systems can be described as overt rationing. In the context of healthcare allocation decisions, overt rationing refers to a situation where the way in which prioritisation decisions are to be made is stated explicitly to the doctor. Also, it is expected that patients will be clearly informed of the reasons why they did or did not receive a particular treatment. However, current research has demonstrated that another form of rationing, *viz.* 'covert rationing', is often present within clinical encounters. Covert rationing refers to allocation that occurs 'under wraps', i.e. where the reasons for a treatment being withheld are not made available to the patient. Covert rationing has been highlighted as occurring often in relation to age and the elderly. Marshall and Kapp wrote that, 'limiting various forms of medical treatment...on the basis of chronological age is one of the world's best known secrets.'¹⁶

Covert rationing often occurs because prioritisation guidelines are nebulous or unclear. It can also occur in situations where priority criteria are difficult for the public to access or in situations where information relating to why an individual did not receive treatment is kept from the patient or family. Research has shown that procedures such as renal dialysis, organ transplantation or cancer treatment have been denied to the elderly on the grounds of medical indications, when in fact, it was on the basis of limited resources.¹⁷ Kramer demonstrates that doctors repeatedly covertly discriminate against the elderly through withholding potentially beneficial treatments in order to save money. This was exemplified through physicians who choose cheaper, less aggressive options for elderly patients when compared to patients who

¹⁶ Kapp and Marshall, "De Facto Healthcare Rationing By Age: The Law Has No Remedy." p. 329

¹⁷ Ibid.

were younger with the same life expectancy.¹⁸ In these cases ‘age was never overtly identified as the sole reason for limiting treatment even though almost half of these very old patients have had some limitation placed on their care.’¹⁹

There are a number of possible explanations for why rationing by age occurs covertly within the clinical encounter. For example, the physician may be acting out of a subconscious bias against the elderly. Alternatively, the physician may intuitively believe that in fulfilling their duty as a healthcare professional they should direct resources to younger individuals.²⁰

When rationing occurs covertly it cannot be discussed in a publicly accountable way. This is problematic because the patient has a right to know the real reasons they were denied treatment. If they were given that information, they may be able to source care from the private sector (if they have the means), whereas if they were told they were denied the treatment on the basis of medical indications they would be unlikely to look into private healthcare options. Therefore, covert rationing can undermine the autonomy of the patient. Moreover, it might be argued that honesty in the doctor patient relationship is a fundamental value and that irrespective of what the patient will do with the information, they have a right to know why they are or are not being treated.

One reason, perhaps, that covert rationing has continued for so long is because it seems to allow policy makers and politicians to avoid being thrust into the spotlight regarding rationing. Covert rationing creates a system where politicians can shift blame onto individual doctors and thus conveniently sidestep accountability for any rationing decisions. This undermines public trust in the medical profession, and can make it difficult for doctors to care for people effectively. Furthermore it undermines the medical profession’s trust in governing authorities, which makes it more difficult to develop clinically informed policies and systems. An overt system of rationing that

¹⁸ A Kramer, "Health Care for Elderly Persons - Myths and Realities," *New England Journal of Medicine* 332, no. 15 (1995). p. 1028

¹⁹ K Hess, "Terminal Care of the Very Old: Changes in the Way We Die," *Archives of Internal Medicine* 155(1995). pp. 1513-18

²⁰ Kapp and Marshall, "De Facto Healthcare Rationing By Age: The Law Has No Remedy." p. 333

is created in a fair and publicly accountable way has a much greater chance of creating a better outcome for all of society. Daniel Callahan makes this point specifically in relation to rationing care for the elderly, and says that while objections to rationing ‘reflect a laudable desire to avoid any future policies that would require limiting benefits to the ageing...a carefully drawn, widely discussed allocation scheme is likely to be safer in the long run for the elderly than the kind of ad hoc rationing that is now present and increasing.’²¹

1.3 Can age-based allocation be justified?

As outlined at the beginning of this chapter, New Zealand’s population is ageing and healthcare spending is predicted to increase rapidly. This has resulted in calls to ration the healthcare resources that are provided to the elderly in order to ensure they do not consume healthcare resources at the expense of other generations. Healthcare is already rationed in New Zealand through methods such as CPAC and QALY, however it is not yet clear how age should feature in our systems of healthcare rationing. There have been claims that rationing by age already occurs covertly, however, this is not an ethical practice and it will not help us in the creation of a just healthcare system. In this thesis I consider whether age-based allocation can be ethically justified, what it would involve in practice, and whether it would address the increasing pressures associated with the ageing population. The view that I come to is that age-based allocation can be justified for certain kinds of healthcare allocation decisions but not for all, and not at the general level of macro-allocation or meso-allocation. This means that an age-based allocation policy should not be introduced to address the described pressures.

Chapters Two through Five of this thesis are concerned with the ethical justification for age-based allocation. In Chapter Two I outline three arguments against age rationing, and argue that these can be overcome so long as the rationing policy is applied consistently over the lifetime of all members of society. This does not in itself provide an argument for age-based rationing but shows that it is theoretically possible. In Chapter Three I outline Norman Daniels’ Prudential Lifespan Account.

²¹ D Callahan, *Setting Limits: Medical Goals in an Ageing Society* (New York: Simon and Schuster Publishers, 1987). p.133

This is an argument for why we should factor age into allocation decisions. His argument explains that we should protect the range of opportunity made available to our citizens, which justifies the denial of care to members of society who have had their share of opportunity, in order to ensure that care is provided to others who have not. It does not, however, provide detailed guidance with regard to who should be responsible for such decisions or from which point in life a person ceases to be entitled to care. Daniel Callahan's work is introduced in Chapter Four as a way of answering these questions. Callahan has developed a set of principles for setting limits on care, based on an argument about what it means to live and die well. These principles show clinicians the type of care they should make available to their patients in order to contain the costs of healthcare for the elderly. The problem we are left with is whether Callahan's principles will, in fact, provide a solution to the challenges our healthcare sector is currently facing.

In Chapter Five I argue that Callahan's principles are already in place within the current model of palliative care, and that while they may limit certain costs associated with elderly care (such as intensive care costs and costs associated with heroic medical intervention), they will not fully address the challenges facing our healthcare sector. We must still reckon with the resource challenges associated with the decreasing number of workers contributing to the overall GDP and tax intake of a country relative to the increasing number of dependents who are not productive in the same ways. Rather than using Callahan's principles to implement the Prudential Lifespan Account, alternatively we could implement a straightforward chronological age cut-off, from which point certain interventions would no longer be provided. However, I argue that it would be wrong to do something as concrete as deny beneficial care to an elderly individual in the name of an abstract ideal – the Prudential Lifespan Account. I go on to explore the reasons why this is: firstly, because the economics involved are uncertain; secondly, because it would be contrary to the clinician's duty of care; and thirdly, because it would inevitably threaten the dignity of those discriminated against (despite this not being the intention of the policy). Therefore, age-based healthcare resource allocation should not be part of our response to the problems facing our healthcare sector. However, these challenges remain and do need to be addressed.

In Chapter Six, I consider some alternative responses that involve members of society making personal contributions to address these challenges. This could involve ‘family-unit’ planning for the future, community strategies or collective savings schemes. These approaches are outlined as possible avenues for further research.

CHAPTER 2: THE JUSTIFICATION FOR AGE-BASED DISCRIMINATION

The issues outlined in Chapter One show us that over the next decade New Zealand policy makers will be motivated to determine ways that money can be saved within our healthcare sector. It is not yet clear how age will be incorporated into this discussion, or how age features in current rationing systems. Take for example a simple problem:

Mr. X

Mr. X is 25 years old, has just finished studying at university and is engaged to his girlfriend. He is a type one diabetic who has been suffering from renal problems over the last five years. The renal physician has indicated that Mr. X would benefit from renal dialysis as his glomerular filtration rate is consistently low. This indicates that his kidneys are unable to do their job properly.

Mrs. Y

Mrs. Y is 75 years old, happily married and has two children and three grandchildren. She has recently developed type two diabetes and has symptomatic renal failure resulting in a chronic indication for dialysis.

For the purposes of this discussion we will assume that there is only one dialysis machine available. The renal physician at Dunedin Public Hospital has been working with both Mr. X and Mrs. Y since commencing his position five years ago. He has calculated that the dialysis will benefit Mr. X and Mrs. Y equally in terms of quality of life. Both patients are likely to respond equally well to the treatment.²²

²² Harris, "Deciding Between Patients." p. 335

The physician needs to decide who should receive the dialysis and this requires considering if there is any relevant difference between Mr. X and Mrs. Y. If no relevant difference can be identified, the fairest way to allocate the dialysis would be through a lottery. I suggest that many of us would intuitively think that the younger person has a greater claim to the dialysis, but there are some who would strongly disagree. The questions underlying this disagreement are difficult to answer. What is it about being older or younger that gives an individual a lesser or greater claim to healthcare resources? Can a differential claim to healthcare resources be justified on this basis?

As outlined in Chapter One, a possible way to calculate a difference between Mrs. X and Mr. Y, which captures the age difference, is through a calculation of the QALYs expected following the treatment. In micro-allocation decisions, such as choosing between Mr. X and Mrs. Y, a simple calculation can be done in order to determine the number of QALYs expected for each patient as a result of the intervention. As Mrs. Y is older, it is likely she will not live as long as Mr. X. Hence, Mr. X would score higher on the QALY scale and be given priority because it seems that he would benefit more from the treatment (in terms of years of life gained).

Though QALYs may fit with the intuitions of the majority in the case of Mr. X and Mrs. Y, they are not unproblematic and there is a general sense of unease surrounding the fact that they seem to penalize persons who have a short life expectancy due to a poor prognosis, or those individuals who have a short life expectancy due to the fact they are older.²³ This uneasiness is not only created through QALY calculations but also seems to occur whenever age is included as a factor in healthcare allocation decisions. Therefore, we need to look for a deeper understanding of why age matters in healthcare resource allocation and connect a specific theory with our broader understanding.

In this chapter I will introduce some recent arguments against age-based healthcare rationing raised by Giordano and Harris in order to lay a platform for a discussion of

²³ Lockwood, "Quality of Life and Resource Allocation." p. 453

age in healthcare resource allocation. These objections centre on the notion that people are morally equal regardless of age. I will show how these concerns can be addressed through a recent argument put forward by Persad *et al* supporting age-based discrimination, which shows how this concern of equal worth can be addressed. They maintain that moral worth and allocation are not necessarily tied together, and argue that so long as the principles of allocation are consistent across a complete life rather than at a particular point in time, differential treatment at particular ages can be justified (so long as this occurs consistently between people). However, this argument leaves a number of questions unanswered. Most importantly, it remains unclear why age should matter, and what would be required in order for members of society to accept the implementation of principles of age-based allocation. I begin to address these questions in the next chapter when I introduce Norman Daniels' theory of just healthcare resource allocation, which is based on a broad theory of justice. Daniels' theory gives us adequate moral foundations and a deeper understanding of how age fits into healthcare resource allocation.

2.1 Arguments against age-based rationing

In this section I will outline three arguments against rationing healthcare resources on the basis of age. Firstly, I will outline Simona Giordano's argument that age-based allocation is a breach of the principle of equality. I will then outline two further arguments put forward by John Harris. The first is that healthcare rationing by age cannot be justified because of the strong desire all individuals have to continue living. This desire, he says, exists regardless of their age. The second is closely related, but refers more directly to the value of a life. Harris argues that all lives have equal value irrespective of age and that denying healthcare interventions to individuals over a certain age would be to assign the lives of those individuals a lesser value.

2.1.1 Giordano: the principle of equality

Simona Giordano has outlined an argument condemning age-based discrimination as a violation of the principle of equality, which she defines in terms of nondiscrimination.²⁴ She links equality with justice, invoking Aristotle's 'justice is

²⁴S. Giordano, "Respect for Equality and the Treatment of the Elderly: Declarations of Human Rights and Age-Based Rationing," *Cambridge Quarterly of Healthcare Ethics* 14, no. 1 (2005). pp. 83-92

equality'²⁵. Though she acknowledges that equality may be interpreted in different ways, she insists that individuals are 'morally' equal regardless of age, gender or race. Behind this conviction is the idea that humans have an intrinsic worth that does not vary with factors such as age, race or gender. Hence, for Giordano, to discriminate on the basis of age is to deny the moral equality of those individuals concerned, i.e. to deny their basic human worth. Consequently, age-based discrimination in healthcare resource allocation does not align with the principle of equality and therefore cannot be ethically justified.

One obvious response to Giordano is Plato's argument that 'not all men are equal, and therefore they cannot and should not be treated as equals...men should be treated unequally as they are unequal.'²⁶ However, Giordano believes it is a mistake to apply this in the context of healthcare. In her view the inequalities Plato is referring to do not encompass the notion of moral worth. She maintains that all people must be regarded of equal worth, and they should only be treated differently insofar as such differentiation is necessary in order to uphold their worth (this in her view is the correct interpretation of Plato's argument). The right to healthcare is, she believes, something that all people have as a result of their basic human worth; it should not vary according to the differences that exist between people including their age. She asserts that if society were to assign the elderly a lower entitlement to healthcare resources this would be a 'violation of the fundamental human rights and universal ethical principles stated in declarations, conventions and charters of human rights.'²⁷

In response to Giordano it should be noted that people are subject to laws and policies on the basis of a number of factors, one of which is age. For example, we are not permitted to purchase alcohol before we reach age eighteen, and once we reach age eighteen we are no longer entitled to free dental care. Nobody, it seems, thinks that the allocation of free dental care to those under the age of eighteen makes them worth more than those individuals over the age of eighteen. This appears to undermine

²⁵Ibid. pp. 83-92

²⁶Plato, "The Laws," (1960). p. 757 In: Giordano, "Respect for Equality and the Treatment of the Elderly: Declarations of Human Rights and Age-Based Rationing," p. 84

²⁷Giordano, "Respect for Equality and the Treatment of the Elderly: Declarations of Human Rights and Age-Based Rationing," p. 88

Giordano's link between the notion of moral worth and healthcare allocation. It seems at least possible that age can be a factor in allocation decisions without compromising the value of those affected by the policy. This still leaves open the question of how age should be taken into account (if at all) and which treatments this factor should be applied to. There may be some forms of healthcare that all people should be entitled to irrespective of age and in these cases Giordano's point would stand. These questions need to be answered and I will aim to address them in the following chapters. However, before proceeding I will review two arguments that have been put forward by Harris.

2.1.2 John Harris: the anti-ageist argument

Like Giordano, John Harris has also argued that age should not be a relevant factor of consideration in healthcare resource allocation. His argument rests on the idea that everyone who wishes to continue living has 'the rest of her life' remaining, and as long as we are not aware of the date that our death will occur, this is of 'indefinite duration'.²⁸ Hence, if we die prematurely and are robbed of the rest of our lives (which regardless of our age is of indefinite duration) then we all suffer the same injustice.

Harris claims that the life we have left to live is precious to all individual regardless of the particular length it may be. Hence, the value of life is linked to the desire to continue living. This desire, he argues, is equally strong for individuals regardless of their age and therefore it 'denies the relevance of age or life expectancy as a criterion absolutely...if we both want, equally strongly, to go on living, then we each suffer the same injustice when our lives are cut short.'²⁹ In this view the 'wrongness' of an individual's life ending is tied to their desire to go on living out the unelapsed years of their life. Harris argues that the equal desire all individuals have to continue living means we could not deny healthcare resources to elderly individuals on the basis of age.

²⁸ J. Harris, *The Value of Life: An Introduction to Medical Ethics* (New York: Routledge Publishers, 2003). p. 88

²⁹ *Ibid.* p. 88

Harris adds another dimension to his argument by asserting that it will be a ‘double injustice’³⁰ if society mandates that an individual whose life expectancy is short should not be given a treatment that will benefit them. If an elderly person is given a poor prognosis they suffer the tragedy of knowing they will not live for much longer. Additionally, if limits were based on care for the elderly they would be troubled again with the news that because of their age they would not be given beneficial care. This double injustice where the unlucky one is no longer worth saving³¹ seems, says Harris, intuitively unfair.

Despite Harris’ claims about a ‘double injustice’, there is a sense in which his position seems at odds with our intuitions. It does not seem to be the same misfortune to lose years at the end of your life when you have already had the opportunity to have a career, successful relationships, children and grandchildren, as compared to dying near the beginning of your life, when you have not yet had any of these opportunities. This is not to say that the life of the younger person is more valuable, but that the older persons life has already been lived. If this is right, then it is more of an injustice to die when you have your whole life ahead of you, rather than when you have lived out the majority of your life.

Furthermore, it should be noted that simply stating that lives have equal value does not lessen the problem of resource scarcity, and provides little insight into how we should make hard allocation decisions. In a society where resource scarcity abounds, allocation decisions are necessary. This means that we find ourselves in situations where we are forced to choose who will receive medical care. However, in making such choices we are not necessarily assigning different values to lives; rather we may simply be determining who has the greatest claim to medical resources. To take a common example, in emergency situations we prioritise individuals on the basis of need. This needs-based discrimination is used to elicit which individual has the greatest claim to medical resources at a particular point in time. One might argue that needs-based allocation follows logically from Harris’ principles because it aims to identify those most at risk with losing their life. However, this neglects the

³⁰ Ibid. p. 89

³¹ Ibid. p. 89

complexity of many needs-based assessments especially when comparing different treatments which have various impacts on people's lives particularly in the context of chronic illness and long term care. What needs mean when caring for the elderly is a very difficult problem. In order to answer these problems we need to go beyond the straightforward observation that every person wants equally to stay alive.

This response to Harris is the same as the response I gave to Giordano. Both claim that age-based allocation would breach a universal entitlement to healthcare, despite the fact that they ground this entitlement in different ethical concepts (Giordano ties it to the notions of moral equality and human rights, whereas Harris ties it to a person's desire to live out 'the rest of her life'). Neither takes due account of the sorts of differences that are regarded as significant in current healthcare allocation policies, nor do they convincingly address the widespread intuition that age does matter in such decisions – that there is, for example, a difference between the death of an eighty year old and the death of a twenty year old. A deeper understanding is required of what makes human life valuable, and of how age relates to this value. In the next two chapters I will explain how Norman Daniels and Daniel Callahan tie value to the notion of opportunity – a view that links back to the theories of John Rawls and Aristotle. This, as we will see, provides a justification for age based healthcare allocation without devaluing the lives of those discriminated against.

2.1.3 Harris: the age-indifference principle

Harris has recently advanced an additional argument on age discrimination in his paper 'The Age-Indifference Principle and Equality'³². Through this he develops another implication of individual value, which is linked to protection by the community. In this paper Harris states that 'an individual's entitlement to the concern, respect, and protection of the community does not vary with age or life expectancy.'³³ Part of Harris' argument here is similar to that of Giordano. He argues that if the elderly were given a lesser claim to healthcare resources this would amount to society saying that elderly lives have less value than younger lives. Harris restates that all lives have the same moral value and that we should not assign lives differing

³² J. Harris, "The Age Indifference Principle and Equality," *Cambridge Quarterly of Healthcare Ethics* (2005), p. 98

³³ *Ibid.* p. 96

values. However, he also adds that the highest priority of any government is to protect the life and liberty of their citizens. He bases this claim in Thomas Hobbes's idea that: 'The obligation of subject to the sovereign, is understood to last as long and no longer, than the power lasteth, by which he is able to protect them'.³⁴ In other words, citizens are expected to obey the law and the social contract and in return the state is required to protect them. This is referred to as a 'social contract'. He then asserts that nowadays the most common threats to humankind are the absence of healthcare and social welfare. It follows, he argues, that the state has a duty to provide healthcare and social welfare to all its citizens.

Social contract theories are designed to explain the legitimacy of the state over individual citizens and the respective duties of each. In the Hobbesian social contract the authority of the state is legitimated by the citizens' need for protection from other members of society. We (the citizens) respect the government that legislates and creates policies for the collective good. This is because the protection of the government is imperative to the survival of a country's citizens. Under the social contract there is an assumption that the rights of citizens will not be disregarded (this includes in existing and accepted allocation decisions). This social contract extends beyond simply healthcare. While Harris argument states that the government should protect the health of citizens through health and welfare, healthcare is only one of a myriad of factors that will influence health. Diet, a good justice system and education, for example, have all been shown to influence health status. Harris' argument requires that money be given to these factors too as they are also a part of protection by the state.³⁵ This means that law-abiding citizens should be provided with medical care (and other factors that influence health) on the basis of their citizenship, not say, on the basis of how old they are.

A significant problem with Harris' argument is that it ignores the problem of scarcity. In society there is a larger demand for government resources (including medical care)

³⁴ Ibid. p. 97

³⁵ N. Daniels, *Just Health: Meeting Health Needs Fairly*, Cambridge University Press (United States of America: Cambridge University Press, 2008). p. 104

than can be met.³⁶ This means the state is required to make difficult choices about the allocation of healthcare resources. Hence we need to consider if the government would, in fact, be breaching its social contract if it were protecting the life and liberty of its citizens to the best of its ability? It seems clear that the duties of the state under the social contract must be moderated by some notion of what is reasonable. Resource scarcity is a reality so there is likely to be some limit of how far the state can 'protect its citizens' in providing healthcare. In the same way that we would expect citizens to obey the social contract to the best of their ability, we cannot expect more than this from our government.

Though Harris seems to be making unreasonable demands of the state in asserting that every person should be entitled to universal healthcare throughout the entirety of their life, the point he makes about the obligation of the state to protect its citizens through healthcare is legitimate. An age-based allocation policy needs to be supported by something like a social contract. This is another reason to explore Norman Daniels' theory, who links healthcare allocation to John Rawls' social contract theory.

Interestingly, alongside this argument about the social contract, Harris also reiterates his concern about human value echoing the arguments put forward by Giordano. He argues that the use of age in allocation decisions would devalue our elderly citizens and lead to negative beliefs regarding the elderly. 'It might', he suggests, 'lead to an increasing tolerance of the idea that any and all resources, or even care, devoted to the old or those with life-threatening disease was a waste of time money and emotion.'³⁷ This argument is an example of a 'slippery slope argument'. In this form of argument a change (the introduction of age-based rationing) is linked with negative consequences (tolerance of the idea that any care for the elderly is a waste of money) through a causal chain consisting of several links.³⁸ In this case, the predicted consequences *viz.* society believing that care for the elderly is a waste of money, are unacceptable. However, this is only a prediction. An extrapolation such as this does

³⁶ The notion of resource scarcity is complicated and contestable. I will look more closely at this in Chapters Five and Six.

³⁷ Harris, "The Age Indifference Principle and Equality." p. 98

³⁸ K. Hartogh, "The Slippery Slope Argument," in *A Companion to Bioethics: Second Edition*, ed. H. Kuhse and P. Singer (West Sussex: Wiley Blackwell Publishers, 2012). pp. 321-22

not offer a strong argument against the implementation of a policy because we cannot be sure that the extrapolation will bear out.³⁹ In the final section of this chapter I will briefly introduce an argument for healthcare allocation by outlining an argument put forward by Persad, Wertheimer and Emanuel. This is important because it provides a way of addressing the concerns about equality and moral worth that have been put forward by Harris and Giordano. The solution offered resembles the position arrived at by Daniels and so he offers a useful platform from which to explore their ideas further.

2.2 Persad, Wertheimer and Emanuel: Complete Lives System

An argument for age-based discrimination has been recently advanced by Persad *et al*, called the ‘Complete Lives System’. Like the arguments offered by Giordano and Harris, this argument appeals to our intuitions. The core idea is that so long as the distribution system is applied consistently over a life it does not necessarily assign different value to different lives. In this section I will outline the Complete Lives System along with an important objection.

Persad *et al* argue that age should be a factor considered in the allocation of healthcare resources. They propose what is termed a ‘modified youngest first principle’, along with principles of prognosis, lottery, saves the most lives and instrumental value. They argue that we should prioritise healthcare resources to people between the ages of fifteen and forty.⁴⁰ There are three parts to their overall argument: the complete lives argument, the modified youngest first principle and the consistency argument.

2.2.1 Complete lives argument

This argument is based on the notion of a ‘complete life.’ While Persad *et al* do not define what a complete life encompasses, for the purposes of this discussion I am treating ‘a complete life’ as synonymous with ‘a lifespan’. Their argument can be outlined as follows: in a complete life, each year of life has value. Younger people have had less years of life and therefore had less of something valuable. Healthcare

³⁹ I will revisit this in Chapter Five, section 5.3 ‘Implications of age-based rationing policies’.

⁴⁰ G. Persad, A. Wertheimer, and E. J. Emanuel, "Principles for allocation of scarce medical interventions," *Lancet* 373, no. 9661 (2009). pp. 423-31

interventions should be distributed so that everyone has an equal share of value. Healthcare interventions that increase the years of life lived should therefore be allocated to people who have had less years of life, because they have had less of something valuable, *viz.* life years.

2.2.2 *Modified youngest first principle*

The modified youngest first principle guides us to prioritise healthcare resources to individuals aged between fifteen and forty years old. This is an alternative to the pure youngest first argument initially put forward by legal philosopher Ronald Dworkin. The pure youngest first argument would see preference given to younger individuals. Persad *et al* base the modified youngest first principle on the thought that ‘it is terrible when an infant dies, but worse, most people think, when a three-year-old child dies and worse still when an adolescent does’.⁴¹ They state this is because over time individuals invest in us, with, for example, time, money or teaching. A younger individual (under the age of fifteen) will have had less invested in them by society, therefore it is a lesser tragedy if they die. A twenty year old has had more investment than a five-year-old who has, in turn, received a larger investment than a two-year-old. Individuals aged closer to twenty will have begun to ‘use’ the investment of others and it is likely that they will have commenced some ‘as yet unfilled projects’.⁴² Furthermore, as an individual grows from infant to twenty, they develop their own personality, hopes for the future and expectations. We would not see these developed to the same extent in a very young child. Hence, investment from others and the development of personality and personal hopes for the future form the basis of the claim that preference with regard to healthcare resources should be given to, say, a twenty-year-old over a five-year-old. Similarly priority should be given to a five year old over a two-year-old – this is the ‘modified youngest first principle’.

2.2.3 *Consistency argument*

Many healthcare goods, such as a surgical procedure, an organ transplant or an injection are indivisible i.e. you will either get the whole treatment or nothing at all. From this it follows that because one cannot provide equal portions of interventions (say half a heart transplant) to all individuals who need the treatment, the next best

⁴¹ Ibid. pp. 423-31

⁴² Ibid. p. 425

alternative is to provide an equal chance to all individuals of receiving the treatment, or equality of opportunity to receive healthcare resources. The consistency argument states it is fair to discriminate on the basis of age so long as the policy is consistently applied throughout the lives of the persons concerned. So, at thirty I would be entitled to treatments ahead of someone who is eighty (other things being equal), and when I am eighty I would miss out on treatments if there is a person who is thirty who needs them (other things being equal). This system is fair because it is applied consistently across my lifetime: though my claim to particular interventions will decrease as I get older, over a lifetime I will be provided with equal opportunity to receive healthcare. In other words, Persad *et al* argue that because everybody grows old (unless death prevents them from doing this), allowing age to guide healthcare resource allocation is not negative discrimination because it does not violate the requirement of treating people as equals. Conversely, prioritising allocation on the basis of race or gender would be discriminatory because gender or race do not change throughout a person's life.

2.2.4 *An objection to the modified youngest first principle*

The Complete Lives System has been criticised on a number of points. Bognar and Kerstein have rejected the modified youngest first principle as unfair discrimination against children.⁴³ They argue that it contradicts Persad *et al*'s basic claim that the young 'have had less of something supremely valuable – life years'.⁴⁴ Denying resources to persons who are under the age of fifteen and who have not yet had a chance to live a complete life does not direct resources to those who have had the least of those 'supremely valuable life years'. Hence, people who are under the age of fifteen would be hit with a 'double-whammy'.⁴⁵ Not only are these people dying young (before they have had the opportunity to live a full life), it is for that same reason that they are going to be denied beneficial treatment. In other words Bognar and Kerstein reject the modified youngest first principle because it contradicts the basis on which age-based discrimination is argued for.

⁴³ S Kerstein and G Bognar, "Complete Lives in the Balance," *The American Journal of Bioethics* 10, no. 4 (2010). pp. 37-45

⁴⁴ Persad, Wertheimer, and Emanuel, "Principles for allocation of scarce medical interventions." p. 423

⁴⁵ Kerstein and Bognar, "Complete Lives in the Balance." p. 41

My concern here is not to defend the modified youngest first principle. I introduce Bognar and Kerstein's objection because it further illustrates the fact that there are conflicting intuitions about the ways in which age is significant in healthcare allocation. On the one hand chronological age – or 'years of life' experienced – appears to be significant; on the other hand 'potential' – or the extent to which a life is formed – appears to also matter. This again highlights the need for a deeper analysis of how age matters in making allocation decisions – an analysis which can integrate these apparently conflicting intuitions.

As an aside, the debate around the status of embryonic life is relevant to this discussion. The fact that people grieve differently over a miscarriage than over the death of an infant has often been used to show that there is a morally significant difference between the early embryo and the more developed infant. Given that this distinction does not seem reducible to any characteristic (or set of characteristics), it is often regarded as a matter of 'degree', e.g. the degree to which the life has 'formed'. Viewed this way, the life of the embryo is morally significant, but the life of the infant is more so, because the life is more fully formed. This perspective could be used to support the 'modified youngest first principle'.⁴⁶

The link between moral significance, potential and form is also picked up in Daniels' and Callahan's views on end of life care, as I shall show in the next two chapters. Both consider the value of a particular treatment or intervention under the notion of a 'natural lifespan', which – broadly speaking – refers to the amount of potential that has been actualized in a person's life and the amount that could be reasonable accepted given the inevitability of death. As a life approaches its natural end, where there is less 'opportunity' available, it is appropriate – they argue – to limit life-extending care particularly where this is necessary for care to be provided to other persons who have not yet had their share of opportunity.

⁴⁶ For a discussion of the link between form, potentiality and the significance of prenatal life see: G Gillett, *Subjectivity and Being Somebody: Human Identity and Neuroethics* (UK: Imprint Academic Publishers, 2008), particularly Chapter Two pp. 9-29

2.3 Conclusion

I have outlined three arguments against age-based discrimination. The first is based on the notion of equality, the second on ‘our equally strong desire to continue living’, and the third on the idea that age based discrimination would lead to a devaluing of the elderly. Following these arguments it appears that a lottery would provide the fairest way to decide who of Mrs. Y or Mr. X should receive the dialysis.

By contrast, Persad *et al's* Complete Lives System gives preference of healthcare resources to individuals between the ages of fifteen and forty. They argue that age based principles of allocation can be fair if they are applied consistently over a lifetime. Following their ‘modified youngest first principle’, Mr. X should be given the treatment over Mrs. Y.

In reviewing these theories a number of questions have come to light. Why should age matter in allocation decisions and in regard to which treatments should it be considered? Is there a significant connection between entitlement to healthcare and human worth? What is this entitlement founded upon (is it simply the desire to live as Harris stated, or the relationships that we have to society or the years that we have lived as Persad and colleagues say)? These questions need to be answered in a form that members of society can collectively endorse perhaps through some notion of a social contract. Norman Daniels’ has done this in his theory of just healthcare and the Prudential Lifespan Account. I will discuss these in the next chapter.

CHAPTER 3: NORMAN DANIELS' PRUDENTIAL LIFESPAN ACCOUNT

In the previous chapter I discussed the three most common objections to age-based discrimination: firstly, it denies the fundamental rights of the elderly to be treated equally; secondly, it would not account for the strong desire we all have – regardless of our age – to continue living; finally, it would not open the door to broader forms of negative discrimination towards the elderly. These objections, I argued, can be overcome through the consistency argument where we separate the ‘fairness decision’ from the ‘worth’ assessment and compare individuals across a lifetime, rather than at a particular point in time. Consequently, differential treatment at particular ages can be justified so long as this occurs consistently between individuals. In other words, treating individuals of different ages differently does not mean their lives have a greater or lesser value; but rather that they have a different claim to healthcare resources due to their disparate life stages. This however still leaves questions unanswered. In particular, it is not precisely clear in what sense age matters. The number of life years (years of life/quantity) does not seem to be specifically the issue. Though it appears that many people would see a relevant difference between individuals who have, for example, fifty years separating their ages, the same people may regard a difference of only five years as irrelevant. In addition, the moral justification for age discrimination has not yet been clearly explained, which means in turn that it is unclear what would be required for members of society to accept an age dependent entitlement to healthcare. Persad *et al*'s ‘Complete Lives System’ is based primarily on intuitions and so does not answer these questions.

In this chapter I will introduce Norman Daniels’ theory of ‘just healthcare’, which is based on John Rawls’ broad theory of justice. This is a ‘social contract’ theory formed around the idea of hypothetical deliberators under a veil of ignorance who will determine the principles that will result in a just society.⁴⁷ Daniels applies this social

⁴⁷ A social contract is a theory or model that addresses questions surrounding the foundation of a society and the validity of any authority of the state over the individual. These typically assume that

contract theory to the matter of healthcare resource allocation. He argues that hypothetical deliberators would prefer a system providing all individuals an equal chance to reach a normal lifespan, even if having this equal chance decreased the likelihood of them living a longer than average lifespan.

Daniels' argument was first outlined in *'Am I My Parents' Keeper?'* (1988) and reworked in *'Just Health: Meeting Health Needs Fairly'* (2008). As previously outlined, he argues that age-based discrimination can be justified through procedural justice and the original position put forwards by John Rawls.⁴⁸ Like Persad *et al*, Daniels claims that if we treat individuals differently at different ages consistently throughout their lifetimes then we are, in fact, treating individuals equally. He writes that 'differential treatment by age, over time, is not unequal treatment of persons, even if it is unequal treatment of age groups on each occasion at each moment.'⁴⁹ What he adds to Persad's system is a theoretical moral foundation, and with this an explanation of why age differences matter in healthcare resource allocation. In the first part of this chapter I will provide a brief summary of Rawls' Theory of Justice. I will then go on to set out Daniels' application of this to healthcare, and explain what he terms the 'Prudential Lifespan Account', which underpins his understanding of the relationship between age and entitlement to healthcare.

3.1 John Rawls: A theory of justice

Rawls believes that justice and truth are the most important virtues of human beings. He claims that the application of principles of justice as 'governing philosophies' would result in the best outcome for society. His discussion relates particularly to the issue of 'social justice', which is 'the way in which the major social institutions (the political constitution and the principal economic and social arrangements) distribute fundamental rights and duties and determine the division of advantages from social cooperation.' These major social institutions underpin the rights and liberties of

members of society have consensually surrendered some of their freedoms and submitted to a higher authority (such as a ruler, magistrate or government) in order to ensure their rights are protected.

⁴⁸ Procedural justice is the idea of fairness in the processes used to resolve disputes and allocate resources. This can be contrasted with the notion of distributive justice, which refers to fairness in the distribution of rights and resources, rather than in the process that determines their distribution.

⁴⁹ N Daniels, *Am I My Parents' Keeper? An Essay on Justice Between the Young and the Old* (Oxford: Oxford University Press, 1988). p.139

members of society, and as such have a strong influence on the lifetime prospects of individuals.⁵⁰

3.1.1 *Social contract theory: 'original position' and 'veil of ignorance'*

In order to determine how principles of justice could be developed to govern society, Rawls firstly introduces the notion of the original position. This is a hypothetical situation where rational individuals come together recognising the need to have a society. This means they need a 'social contract', i.e. a set of rules that will govern that society. Whilst in the original position these individuals decide on the principles that will underpin the intuitions within that society and how goods will be assigned within that society. It is to be 'understood as a purely hypothetical situation characterized so as to lead to a certain conception of justice'.⁵¹

To ensure that the principles decided upon are fair, Rawls proposes that individuals in the original position (the 'hypothetical deliberators') pass through what he calls the 'veil of ignorance'. This means that whilst deciding the rules that will govern society, the hypothetical deliberators will be ignorant to the state they will find themselves in as members of the society. That is to say, they are blinded to health status, economic status and any other factors that could bias the way they may deliberate. Rawls describes this as follows: '[behind the veil of ignorance] no one knows his place in society, his class position or social status, nor does anyone know his fortune in the distribution of natural assets and abilities, his intelligence or the like.' The result is that the hypothetical deliberators will not create principles that favour their particular condition or circumstance.⁵²

The notion of the social contract is important in regard to this discussion about age and healthcare allocation because it provides the basis on which a person accepts the laws of the society he or she lives in, including the policies determining how

⁵⁰ J Rawls, *A Theory of Justice* (Cambridge: The Belknap Press of Harvard University, 1971). pp. 4,7

⁵¹ It is important to realise that Rawls thinks of us (human beings who want to create a society) in a way that is similar to Kant. Kant focused on our ability to take the process of rational deliberation seriously and this was the basis of any moral action. Rawls' theory of justice is also embedded in a process of rational deliberation. Ibid. p. 12

⁵² Daniels, *Am I My Parents' Keeper? An Essay on Justice Between the Young and the Old*. p. 12

healthcare resources are allocated. As Harris pointed out in his Age Indifference Principle argument, any system of allocation requires the acceptance of those citizens who live under it. Harris, recall, argued that the Hobbesian social contract shows that it is right for citizens to accept the authority of their government as this enables the government to protect them. From this standpoint, protecting its citizens is the primary duty of the state, and for Harris protecting includes providing healthcare. Accordingly if the government fails to provide this healthcare, it will be in breach of its social contract and from that point onwards the citizen will no longer have any obligation to accept its authority. The Rawlsian social contract is based on the same framework for establishing state authority and the duties of citizens, but involves a different process of reasoning (grounded in the Kantian notion of universalisability) and a more positive conception of society, in that it includes a consideration of how society can promote the wellbeing of all members of that society, as opposed to simply protecting them from harm.⁵³

In other words, the Rawlsian social contract is important because it provides a moral foundation to Daniels' argument for an age dependent entitlement to healthcare. In doing so it addresses the second question restated at the beginning of this chapter – what would be required in order for society to accept this notion of an age dependent entitlement to healthcare? In Daniels' Prudential Lifespan Account it is this hypothetical contract that enables a society to 'buy into' those principles of age-based allocation of healthcare resources and support their implementation. It does this through showing us that age dependent entitlement can be rationally acceptable to all members of the society. In this system, acceptance of the social contract does not solely depend on whether the state can 'protect' them, as Harris claimed (though this of course is likely to be an important aspect of the social contract that emerges from the original position), but refers fundamentally to what is rationally acceptable to everyone. Thus, supposing members of society follow the reasoning involved in the contract, they will be able to accept their age-based entitlement to healthcare resources, having recognised that this will result in the outcome that is 'right' for all.

⁵³ Rawls political theory is closely tied to Kant's moral theory.

3.1.2 Rawls' two fundamental principles

Rawls argues that in the original position the hypothetical deliberators will agree on the creation of a society with two fundamental principles. These will provide guidance for the development of further principles. Firstly, all citizens will have basic civil liberties and be free and equal in terms of worth or status. This means that your status is the same as everyone else and what is acceptable for you will be acceptable for everyone. The second fundamental principle is that the greatest benefit should be delivered to the least advantaged members of that society.

As these principles are generated under the veil of ignorance, they are meant to reflect the reasoning of a person who imagines him or herself as being any member of the society: young or old, rich or poor, powerful or vulnerable, healthy or sick, and so on. The first principle follows easily from this given that no person would willingly subjugate himself to another person, or give another the right to, say, treat him or her as being of 'less worth', or allow himself or herself to be imprisoned for no reason (the social contract does make citizens 'subject' to certain authorities, but it is – in principle – the 'office' that the citizen is subject to, not the individual that holds that office). The second principle is slightly more complicated. It follows from the hypothetical deliberator considering herself in a 'worst case scenario'; for example, as being chronically ill or disabled, or unable to care for herself, or as an elderly person reaching the end of her life without a family or friends to care for her. They consider 'what if that was me?' 'How would I want society to respond if I was in that situation?' The second principle is a statement about how the deliberators would want society to respond to individuals who are 'disadvantaged' in these ways. The underlying thought is: 'if I was disadvantaged in this way I would want those who are not so disadvantaged to help me'. If one accepts this, it becomes reasonable for people to help those who are 'naturally' worse off through ill-health or misfortune. The outcome is that in the resultant society 'social and economic inequalities are only just if they result in compensating benefits for everyone, and in particular for the least advantaged members of society.' This means (in theory) that no matter where you

end up in society, the state will – in so far as it can – provide the resources necessary to give you the best possible chance you could have of living well.⁵⁴

3.1.3 *Reflective equilibrium*

In setting out his theory of justice, Rawls introduces the concept of ‘reflective equilibrium’. This is proposed as a methodological instrument for the formation of ethical theories, which relates the ethical theory to our existing moral sensibilities.⁵⁵ ‘Reflective equilibrium’ refers to a situation where the principles of the theory align appropriately with our intuitions i.e. a situation where we find a solution to our initial problem that involves a combination of both reasonable conditions (or principles) and our considered judgments (or intuitions). If there is a conflict between the theoretical principles and our intuitions, this suggests there is either a problem with some part of the theory or that our judgments may need to be adjusted. In his *Theory of Justice*, Rawls suggests that his hypothetical deliberators need to continually alter both their judgments and the principles they develop. In the process of deliberation both intuitions and principles shift, ‘going back and forth, sometimes altering the conditions of the contractual circumstances, at other times withdrawing our judgments and conforming them to principles’. Rawls believes that it is through this quest for reflective equilibrium that the hypothetical deliberators will create sound principles.⁵⁶

3.1.4 *Honneth and Andersons’ objection to the Rawlsian view*

Rawls’ *Theory of Justice* has been the subject of much debate and criticism but nevertheless remains influential forty years after it was first published. Before proceeding to Daniels theory I will briefly discuss one interesting objection recently put forward by Axel Honneth and Joel Anderson. This objection is important because it highlights the procedural nature of Rawls’ theory of justice.

Honneth and Anderson criticize Rawls’ characterization of the hypothetical deliberators, arguing that their starting point of ‘individualistic liberty’ makes their reasoning too ‘instrumentalist’, i.e. too focused on the needs of the individual

⁵⁴ Rawls, *A Theory of Justice*. p. 12

⁵⁵ R Gillion, "Ethnography, medical practice and moral reflective equilibrium," *Journal of Medical Ethics* 22(1996).

⁵⁶ Rawls, *A Theory of Justice*. p. 20

deliberator. They argue that the hypothetical deliberators should not be characterised by individualistic liberty but rather by an awareness and acknowledgement of the interdependent nature of society. They state that in order to create a flourishing society, people must firstly develop relations with others and then recognise how these relationships influence their own life. The conclusion Honneth draws from this is that the realisation of personal liberty needs to be based on the existence of supportive relationships with others rather than simply individualistic liberty.⁵⁷

In response to Honneth and Anderson, it must firstly be remembered that the social contract is initially created because there is a recognised need to have a society. Individuals in the original position have come together because they know that in order to survive they need to live together and so must create principles that will allow them to do so. This suggests that a Rawlsian society is in fact based on an acknowledgement of our interdependency. Relationality, one might say, is implicit in the idea of a social contract. However, acknowledging our interdependent and relational nature does not in itself tell us how our various relationships should be ordered and maintained. The purpose of a social contract theory is to answer these questions.

This response to Honneth and Anderson is supported by Miriam Bankovsky, who highlights the original position as the process of working through ‘social problems’ (the problems that emerge as we try to live together). Bankovsky states that the basis of Rawls’ ‘constructivism’⁵⁸ is the use of hypothetical deliberators as ‘agents of construction’, whose task it is to meet social problems through a process of discussion and justification of their intuitions as a group. In other words Rawls uses constructivism to connect the idealised person (a hypothetical deliberator under the veil of ignorance) with the creation of principles of justice. Therefore, the hypothetical deliberators do not argue from a standpoint of individualistic liberty;

⁵⁷ A. Honneth and J. Anderson, "Autonomy, Vulnerability, Recognition and Justice," in *Autonomy and Challenges to Liberalism*, ed. J Christman and J Anderson (Cambridge: Cambridge University Press, 2005).

⁵⁸ Constructivism is a theory of learning that emphasises the way individuals create meaning through individual constructs. Constructs are the ‘filters’ that we place over our realities in order to change them from chaos to order.

rather they are aware that they will be interdependent with all other members of society and the social contract is created because of this shared need to have a society. The recognition of this interdependence, rather than a presupposition of individualistic liberty, creates a system that benefits both individuals and society as a whole.⁵⁹

The procedural nature of Rawls' theory of justice is important because the problems of maintaining and ordering relationships change over time. They change as the environment or economy changes, as technology develops, or as society becomes more aware of the needs of individual members (i.e. as people gain a more adequate understanding of what it is actually like to be in the position of another member of our society). Thus, members of a just society must 'reenter' the original position and discuss specific questions of justice as they arise. The question of age and healthcare allocation is an example of such a question (brought about by changes in the population structure of societies, increased expectations of the healthcare sector and an increase in the use of expensive medical technologies), and this thesis is itself an attempt to engage in the required discussion. This brings us to Norman Daniels. Daniels is a contemporary political theorist and bioethicist who has made a significant contribution to this discussion about age and healthcare allocation, and so his work is highly relevant to my project.

3.2 Application to healthcare: Norman Daniels' Prudential Lifespan Account

As has been noted, Norman Daniels' work applies Rawls' theory of justice to issues of healthcare resource allocation. It is an attempt to answer the question: what would healthcare resource allocation look like in a just society? As an application of Rawls' theory, Daniels' position is rooted in procedural justice where 'the fairness of the outcome...is derived from the fact that it is reasonable to let these deliberators decide the choice for us.'⁶⁰ Therefore, if we can accept this process of creating a system of healthcare resource allocation we should be able to accept the outcomes of this system as just.

⁵⁹ M Bankovsky, "Social Justice: Defending Rawls' theory of justice against Honneth's objections," *Philosophy and Social Criticism* 37, no. 95 (2011). p. 97

⁶⁰ Daniels, *Am I My Parents' Keeper? An Essay on Justice Between the Young and the Old*. p. 93

The conclusion that Daniels arrives at is that in a just society value should be placed on opportunity and hence members of society should have their share of opportunity to fulfill what he terms the ‘normal opportunity range’. This is the ‘range of plans one could expect reasonable members of society to make at each life stage.’⁶¹ A part of this is the opportunity to live a ‘full life’. In order to ensure this occurs, he argues that the hypothetical deliberators would choose a system that provides all individuals with an equal chance to reach a normal lifespan, even if this means that having reached that average age they will have a decreased chance of living a longer than average lifespan. I will now discuss his argument and explain how he reached this conclusion.

3.2.1 Broad application of the Rawlsian view

Before considering Daniels’ application of Rawls’ theory to the question of age-based allocation, it is worth considering what it involves for healthcare allocation generally. As outlined earlier, Rawls’ first principle states that all citizens are free and equal. This means that everyone’s basic rights will be respected. When this is applied to healthcare resource allocation it means that all citizens will be subject to the same rules of entitlement as everyone else, and that differential treatment will be based on fair principles and not, for example, on the basis of individual preferences or prejudices. His second principle states that society should be structured in such a way that the greatest benefit is delivered to the least advantaged members of society i.e. those who are disadvantaged will be helped more. This principle seems to fit with the ‘need-based’ allocation policies that are already customary in healthcare globally. For example, in the emergency department of a hospital ‘triage’ occurs.⁶² This is the process by which the treatment priority of patients is determined according to the severity of their condition. Individuals who have life threatening injuries from a car accident will be given priority over individuals who have less severe conditions i.e. patients with the greatest need will be seen first. Within New Zealand’s public health system many allocation decisions are grounded on an assessment of which patient is currently the most needy. As outlined in Chapter One, in the context of elective procedures, in order to determine who has the most need and hence who will be given priority New Zealand uses CPAC (clinical priority assessment criteria) from which a

⁶¹ Daniels, *Just Health: Meeting Health Needs Fairly*. p. 58

⁶² See Chapter Two, p. 15.

patient is scored according to their need and potential to benefit.⁶³ Another example of delivering benefits to the least advantaged members of society (in terms of natural goods and/or the genetic lottery) is shown through people with disabilities in New Zealand receiving a greater share of healthcare resources. The goal is to ensure that such people get as ‘normal’ a life as possible (where ‘normal’ is measured against the current access to, and availability of goods enjoyed by able-bodied members of society). Or, to express this using Daniels’ terminology: to ensure that they have the best possible chance of attaining the standard of the normal opportunity range.

It seems a strength of Rawls’ theory that his two basic principles of justice fit with so much of what is currently practiced and considered fair in allocation decision-making (they appear, in this respect at least, to achieve a satisfactory level of reflective equilibrium). This suggests that these principles could be productively deployed in discussion of areas where there is uncertainty or disagreement (supposing of course that those involved in the discussion are persuaded by Rawls’ arguments – and it should be acknowledged that not everyone is). So, what about the matter of age in healthcare resource allocation decisions?

3.2.2 *Prudential Lifespan Account*

To answer this question, Daniels makes some additions to the veil of ignorance. These are intended to clarify how the idealized deliberator should regard age in considering the just allocation of healthcare resources. The first addition states that the hypothetical deliberators will be unaware of their own age. The second addition is that they must have a time neutral concern for wellbeing over their life. This means they cannot value their youth (or any other life stage) more than their middle age (or any other life stage). The third addition is that they must plan for each stage of life under the assumption they will survive it.

With these considerations in mind, Daniels argues that the hypothetical deliberators will choose a society that gives each person the best possible chance of living as long a life as possible. Daniels describes this as the ‘Prudential Lifespan Account’, as it is

⁶³ See Chapter One, p. 3.

concerned with the most prudent way healthcare resources can be allocated for all members of society. On this account people should have their chance to attain the standard of the 'normal opportunity range', i.e. the age specific array of plans that reasonable members of the society are likely to make. Resources should be allocated in such a way that each person has the best chance of carrying out those plans. To ensure this occurs the hypothetical deliberators will prefer 'a distributive scheme which improves their chances of reaching a normal lifespan to one that gives them a reduced chance of reaching a normal lifespan but a greater chance to live an extended span once the normal span is reached.'⁶⁴

The reasoning behind the Prudential Lifespan Account is as follows: there is a fixed amount of healthcare resources in society. Individuals in society are living longer and individuals consume a greater amount of healthcare resources over their lifetimes. However, there are not enough extra healthcare resources available to compensate for this increased demand, which means that some healthcare needs will be unable to be met. If a maximising goal is created in this society and individuals are enabled to live for as long as possible beyond, for example, the age of seventy-five, then this goal could only be achieved if resources were redirected from other social services (as there is a fixed amount of healthcare resources). Consequently people would have a lesser chance of reaching seventy-five but a greater chance of living longer once the age of seventy-five had been reached. The hypothetical deliberators will prefer a system that gives all individuals the greatest chance to live a full life and reach, for example, the age of seventy-five, even if it means they have a decreased chance of living longer once they had reached the age of seventy-five.

Daniels argues that an allocation scheme that constrains resources at the end-of-life adheres to the requirements of social justice and creates a higher likelihood of individuals living a full life when compared to, say, a lottery scheme of allocation. He summarises the comparison as follows:

- Under the Prudential Lifespan Account (P) no individual over the age of seventy-five (the normal lifespan of this hypothetical society) will be entitled

⁶⁴ Daniels, *Am I My Parents' Keeper? An Essay on Justice Between the Young and the Old*. p. 86

to life extending technologies. As a direct result of this, there will be an increased availability of resources to invest in improving lifesaving resources. These resources will be enhanced and made available to individuals who have not yet reached seventy-five years of age. Forthwith, the likelihood of individuals reaching the age of seventy-five will be increased within that society.

- Under the Lottery (L) scheme life-extending technologies will be distributed to individuals regardless of their age, in a completely random way. Scheme 'L' takes resources from an earlier life stage in order to provide benefit to later stages of life.

Under scheme 'L' an individual will have a reduced probability of reaching a normal lifespan because access to life saving technologies has been reduced for the young (elderly members of society may be given the intervention which decreases the likelihood of younger individuals receiving it). Therefore, scheme 'L' provides an individual with an increased chance of living a longer than average lifespan, once a normal lifespan has been reached. When comparing the two allocation schemes '...P' might offer a 1.0 probability of reaching age seventy-five (and dying right away), and scheme 'L' might give a 0.5 probability of reaching fifty and a 0.5 probability of reaching one hundred. Both yield the same expected lifespan, but they do so differently.' Daniels posits that prudent deliberators would choose scheme 'P'. This is because under the 'maximin' rule i.e. 'maximize the minimum' scheme, 'P' is preferred because it gives each individual the greatest chance of the longest life.⁶⁵

Through the comparison of the lottery and age-based rationing schemes we can see that trying to ensure that all individuals live for as long as possible (i.e. a maximising viewpoint) would not produce the best outcome for society or our lives as a whole. If we created a society where individuals could live for as long as possible, beyond the age of seventy-five, this maximising goal could only be achieved through those resources being used on individuals who had lived beyond seventy-five, not being used on those individuals under the age of seventy-five. Consequently, individuals would have a lesser chance of reaching seventy-five but a greater chance of living

⁶⁵ Ibid. pp. 179, 888

longer once the age of seventy-five had been reached. However, if we abandon the maximising view point (where all individuals live as long as possible) and apply the Prudential Lifespan Account, a just society would allocate healthcare resources in such a way that individuals are given the greatest chance to reach seventy-five even if they have a decreased chance of living longer once they had reached seventy-five.

The implication of the Prudential Lifespan Account is that limits need to be set on care provided to people who have lived out the normal opportunity range. This will prevent them from consuming resources that need to be directed to those individuals who have not yet had that opportunity. As Daniels puts it, in conditions of resource scarcity as we are currently experiencing:

‘Providing very expensive or very scarce life-extending services to those who have reached a normal lifespan can be accomplished only by reducing access by the young to those resources. Saving these resources by giving ourselves claim to them in our old age is possible only if we give ourselves reduced claim to them in the earlier stages of life.’⁶⁶

According to Daniels’ argument, the prudent deliberators would support the limitation of life-extending and expensive interventions to individuals who had lived through the normal opportunity range in order to ensure that all individuals had their chance to live a normal lifespan/fulfill the normal opportunity range. They would think it wrong, for example, if public health initiatives and primary care had to be sacrificed to fund care at the end-of-life or to those individuals who had already lived a full life.

3.2.3 Objections to the Prudential Lifespan Account

A number of criticisms have been directed at the Prudential Lifespan Account. Here I will consider the ‘Multiple Self Objection’ put forward by Schefczyk. This objection is of interest because it helps us to clarify the nature of Daniels’ argument.

The Multiple Self Objection challenges Daniels’ assertion that hypothetical deliberators must have a time neutral concern for wellbeing i.e. his requirement that

⁶⁶ Ibid. p. 87

we show equal concern for all parts of our lives (this is referred to as ‘the requirement of equal concern’).⁶⁷ This objection targets the notion of a ‘pure time preference’, whereby the location in time that prudent planners make a decision does not affect their decision making, i.e. the idea that an individual would want the same thing for her seventy-year-old self when she was forty and when she was seventy. It is not clear, says Schefczyk, why a person should care about what his or her future self wants. It is, he argues, necessary to answer this question in order to show why a person should budget resources over a lifetime, as the Prudential Lifespan Account requires. Furthermore, he points out that preferences may change greatly over a lifetime, and this makes it impossible to create a scheme in which all preferences are taken into account (for I cannot know my later preferences until I am at that later point in my life).⁶⁸ There is, he contends, no neutral ground where present preferences can be reconciled with future preferences.

Schefczyk grounds his objection on Parfit’s Theory of Personal Identity. According to this theory a ‘person’s existence just consists in the existence of a brain and body, and the occurrence of a series of interrelated physical and mental events.’⁶⁹ Parfit states that we do not exist simply within a body, rather personal identity rests ‘exclusively in terms of psychological continuity and connectedness’⁷⁰ and that the person ‘inside’ a body may change over time. Therefore, a disruption of the continuity and connectedness of personal identity can lead to the development of a new identity or person. According to this theory if the preferences/continuity and connectedness of a person change greatly over a period of time then the old self of an individual (P1) will not identify with their new self (P2). This means that P1 will not identify strongly with P2 and therefore P1 will not feel compelled to promote the wellbeing of P2.⁷¹

⁶⁷ M Schefczyk, "The Multiple Self Objection to the Prudential Lifespan Account," *Journal of Medical Ethics* (2008). p. 32

⁶⁸ Ibid. pp.32-5

⁶⁹ D Parfit, *Reasons and Persons* (Oxford: Clarendon Press, 1984). p. 155 In: Schefczyk, "The Multiple Self Objection to the Prudential Lifespan Account." p. 33

⁷⁰ Parfit, *Reasons and Persons*. p. 155 In: Schefczyk, "The Multiple Self Objection to the Prudential Lifespan Account." p. 33

⁷¹ Schefczyk, "The Multiple Self Objection to the Prudential Lifespan Account." p. 33

Scheczyk's objection probes the fundamental character of Daniels' theory, and conveys a misunderstanding of certain key points. Firstly, he seems to have misunderstood the 'idealised' nature of the deliberators in the original position (they don't know their age). As noted earlier, the original position is not meant to be thought of literally. Rather, it is a way of thinking about how we arrive at universalisable principles. In this respect the notion of 'prudence' is potentially misleading (as Daniels' notes in his response to Scheczyk). Secondly, included in our deliberation is neutrality about our substantive values and the awareness that these can change, and hence 'blocking' the possibility of change is regarded as universally bad. Moreover, there is a need to challenge the coherence of Scheczyk's idea that one actually could change so radically as to become a 'different person'. Any notion of a 'life plan' (which is what 'opportunities' are for) implies continuity over time: a commitment to be 'oneself' in a certain way. The suggestion that one would just abruptly stop being oneself at a certain point is very odd, and so it seems the onus is on the Multiple Self Objection to account for this.

Consideration of Scheczyk's objection is useful because it allows us to clarify the way in which Daniels' intends his notion of the hypothetical deliberators to be used and the way that hypothetical deliberators will view the lives of members of their society. I will explore this further in the next chapter when I outline Callahan's notion of 'biographical age'.⁷² This involves viewing the life of the patient as a whole story and shows us that hypothetical deliberators will take a 'lifetime' view when considering patients. Despite the fact that preferences of individuals do change, hypothetical deliberators must still set about the task of determining what would be best for all members of society. Otherwise, we would find ourselves in a situation where it was very difficult to make any policy decisions.

3.2.4 Implications of the Prudential Lifespan Account, and outstanding questions

The Prudential Lifespan Account shows us that in a just society we will allocate resources in such a way that the normal opportunity range is protected. This means that resources will be allocated to ensure that individuals live a full life, i.e. have the opportunity to enact reasonable plans over at least the average lifespan. If one

⁷² See 'biographical age standard' Chapter Four, p. 52.

generation were to receive a disproportionate amount of resources, to the extent that another generation had a lesser range of opportunity, this would be unjust. Having established this broad principle, the next question to consider is how the Prudential Lifespan Account should be implemented in terms of actual allocation decisions.

When it comes to comparatively straightforward decisions between two people who could both benefit from a single resource, it seems that the Prudential Lifespan account supports some form of ‘youngest first’ policy. For example, if we return to the decision involving Mr. X and Mrs. Y which was introduced in Chapter Two (the decision about who will be given the dialysis), we can immediately see that Mrs. Y has already enjoyed a full life (she has achieved the normal opportunity range)⁷³ whereas Mr. X has not. Therefore the dialysis would be given to Mr. X.

Applying the Prudential Lifespan Account is much more difficult when decisions involve more than two patients and more complex comparisons. Allocation decisions are made at multiple levels and often involve a number of variables. At the macro-level there are decisions about how much money should be directed to healthcare, education, the justice system and so on. At the meso-level there are decisions about the types of services and treatments that will be funded. Finally, at the micro-level decisions are made about individual patients, and often patients’ situations are not sufficiently commensurable to make a determination on the basis of chronological age seem fair. Moreover, allocation decisions at different levels often do not involve direct tradeoffs between patients or services, but involve a number of contested and sometimes unpredictable factors.

Broadly speaking, the Prudential Lifespan Account supports the implementation of a range of publicly funded health interventions, and also other social services such as income support, housing, education (in order to ensure every citizen has the skills to support themselves), and so on. In a just society all citizens should be provided with equal opportunity to live a full life. However, it is not yet clear how society should address the many factors that inhibit people from doing this, and hence it is not clear

⁷³ Assuming that the normal lifespan/life expectancy in this society was 75 years for a female.

what services should be provided, or to whom they should be offered. These complexities are particularly pertinent when considering the question of how age should be factored into healthcare allocation. Given that our population is ageing, and given that people generally require higher levels of care at the end of their lives, then it seems we are naturally inclined towards a situation where the older generation consumes a larger share of resources at the expense of the younger. This means that in order to provide the required equal share of opportunity, healthcare may have to be limited to older generations. However, there are still many questions relating to this that remain unanswered: What sort of resources should be cut toward the end-of-life to ensure a just arrangement? At what point should an individual no longer be provided with life extending care? Who should be responsible for making such decisions? In the next chapter I am going to set out the views of Daniel Callahan, which are – among other things – an attempt to address these questions. Callahan, who is another influential contemporary bioethicist, argues that the application of Daniels’ theory requires a cultural shift in our approach to ageing and dying: a shift in attitudes amongst both clinicians and patients. This shift is necessary, he maintains, to bring our shared thinking about death and dying and related healthcare decisions into line with the principles of justice developed in Daniels’ theory.

CHAPTER 4: AN APPLICATION OF NORMAN DANIELS' PRUDENTIAL LIFESPAN ACCOUNT

In Chapter One I outlined the future projections for spending on healthcare in New Zealand. This showed that a huge increase in spending is expected over the next twenty years due to the ageing population, increased demand for expensive medical technologies, increased expectations of the health sector and an increased life expectancy, among other things. These pressures necessitate some form of change. It may be that tax revenue will have to increase, or that money will have to be taken from other public sectors, or that the standard of care offered through the public health service will have to decrease. Or perhaps there will have to be some other currently unimagined change in the way healthcare is delivered in New Zealand.

If there is to be a reduction in the level of services, or a reallocation from other sectors, then it must be considered who should lose out as a consequence of these reductions or reallocations. It seems that the relevance of age in determining such rationing decisions needs to be considered given the simple fact that the elderly as a group will – on current projections and policies – receive a substantially greater share of healthcare resources, most probably at the expense of the young. How should we regard this emerging discrepancy?

In Chapter Two, I outlined how the most common objection to age-based rationing (that age-based rationing would inherently devalue the elderly) can be overcome if we separate the 'fairness decision' from the 'worth assessment' and compare individuals over a lifetime rather than at a particular point in time. In Chapter Three, I argued that a social contract would be required in order for society to accept the notion of an age dependent entitlement to healthcare, and set out Norman Daniels' application of the Rawlsian social contract to the matter of healthcare resource allocation. According to Daniels, justice requires the allocation of healthcare resources in such a way that we ensure that people have an equal share of what he terms the 'normal opportunity range'. I concluded that whilst Norman Daniels' theory persuasively

shows us that age is relevant in healthcare resource allocation, there is still a need to clarify the sense in which age matters, and how we would apply Daniels' theory to specific allocation decisions.

Daniel Callahan is a prominent bioethicist who has offered a systematic application of Norman Daniels' theory of healthcare resource allocation. Callahan has two main works that apply to the topic of age-based healthcare resource allocation; *The Troubled Dream of Life* (1993) and *Setting Limits* (1987). In this chapter I will draw on both these works to explore how Callahan uses Daniels' Prudential Lifespan Account in his discussion of a 'good death'. Like Daniels, Callahan believes that limits should be set on healthcare, but he argues both from an understanding of justice and from an understanding of what it means for an individual to live and die well. He argues that the application of Daniels' theory requires a cultural shift in our attitude to ageing and death amongst both clinicians and patients. This, he maintains, will lead everyone to think in terms of principles of justice with regard to healthcare decisions, and so move us collectively towards a system of healthcare resource allocation that is in keeping with those principles.

In the first section of this chapter I will outline Callahan's notion of a good death. Following this, I will discuss his application of the Prudential Lifespan Account and how it guides us to a system of healthcare resource allocation that ensures healthcare resources are used in a worthwhile way. His position is that if there are no opportunities left to be 'had' by an individual, no duty will remain to provide treatment that will extend their life.

4.1 Callahan's view on setting limits

Callahan believes that we need to have a shared understanding of what it means to live and die well, in order that we can know – as hypothetical deliberators in the original position – how healthcare resources can be used meaningfully at the end-of-life.⁷⁴ Callahan's understanding of how to 'die well' draws on Philippe Aries'

⁷⁴ This will include a consideration of what is best for the patient, and also the state, family and clinician.

discussion of a 'tame' and 'wild' death. In the next section I will describe these ideas, and summarise Callahan's conception of an 'acceptable' death.

4.1.1 Tame and wild deaths

Callahan argues that over time the deaths most commonly experienced in society have changed in a detrimental way. In order to articulate this changing nature of death in society, he firstly uses Philippe Aries' idea that where death used to be 'tame' it has now become 'wild'. Aries identifies a combination of factors behind this shift. Firstly, deaths used to occur frequently (because lifespans were short and mortality rates were high), in the home and usually whilst loved ones surrounded the individual. In addition, due to the nature of diseases during that period of time⁷⁵, the descent to death was relatively fast and the dying individual would usually remain lucid up to the time of death. Thus, when the so-called 'tame death' occurred it 'was known to be coming, was then prepared for, and took place calmly amid a circle of friends and acquaintances'. Consequently, tame deaths were an accepted and familiar part of life. Whilst they did cause grief, they did not stir up the same fear and dread that death does nowadays.⁷⁶

Aries juxtaposes the historical tame death with the notion of a 'wild death'. The 'wild death', he says, 'is not only a technological death, but a hidden, dirty death, one that is shunned, feared and denied'. In his view, the wild death is prevalent in our modern global society, especially in the developed world. This is mainly due to two factors: firstly, the shift from the age of infectious disease into the age of chronic and degenerative disease. This has resulted in individuals often being ill and disabled for a long period of time prior to death (death occurs 'slowly'). Secondly, the advance of medical technology has led to a fear that individuals will be kept alive longer than they should. Aries maintains that this results in a death that involves a slow, chronic decline where people gradually lose all their functions and spend their final days in a coma, unable to communicate with their loved ones, secluded and degraded in their

⁷⁵ This was the age of infectious disease.

⁷⁶ D. Callahan, *The Troubled Dream of Life: Living With Mortality* (New York: Simon and Schuster Publishers, 1993). p. 30

final descent towards death. These factors have led to death becoming associated with fear and uncertainty.⁷⁷

Callahan believes that misguided use of medical technology is in part to blame for the prevalence of the 'wild death'. He claims that a tension exists between the recognition that an individual has come to the end of their life and a desire to push medical technology as far as possible in order to save that life. This is referred to as 'technological brinkmanship' and according to Callahan:

'It is well recognized that if medical technology goes too far, a person can be harmed, that there is a line that should not be crossed...brinkmanship (is) the gambling effort to go as close to that line as possible before the cessation or abatement of treatment.'⁷⁸

In other words, Callahan sees medical professionals as unable to strike a balance between prolonging the life of their patients and prolonging their death. This results in patients being kept alive longer than is necessary, with a diminished quality of life. Accordingly, the longer the life (or death) of an elderly individual is prolonged, the smaller their chance of a good death becomes. In this view 'more time is not likely to offer a better life, but it will almost certainly decrease the likelihood of a good death'.⁷⁹ Callahan believes that society has lost its way in the path to death and that medical technology combined with a new age of diseases has resulted in what he described as a harmful approach to death. To correct this problem Callahan argues that we need to learn to accept the fact that death will happen, to distinguish between extending life and prolonging death, and to set limits on care accordingly.

Much has of course changed in medicine in the twenty-five years since Callahan first published these ideas. One may argue that since the genesis of Cecily Saunders' Hospice movement in the 1960s and subsequent introduction of palliative care as a medical specialty, that healthcare professionals have learned to make the distinctions

⁷⁷ Ibid. p. 30

⁷⁸ Ibid. p. 41

⁷⁹ Ibid. pp. 41, 184

that Callahan describes and have developed a more accepting approach to death.⁸⁰ However, it is still an open question as to how far Callahan's vision has been realized. I will now outline his notion of an 'acceptable death' and what he thought this meant for clinical practice.

4.1.2 *An acceptable death*

Callahan believes that if we could grasp the notion of an acceptable death this would lessen the need for technological brinkmanship. He argues that if we could recognise the time that death is appropriate in the life of an individual we would no longer have to fight their death thus technological brinkmanship would not occur. His view is that we cannot have life without death and after a lifetime of flourishing and opportunities, death is natural. Hence at the right time, in the right circumstances death may be acceptable. Callahan outlines two constraints that he uses to define an acceptable death. I will explain each of these below.

Firstly, 'death is acceptable when further efforts to defer dying are likely to deform the process of dying.' The underlying assumption behind this constraint is that there is a 'natural' process of dying that can be deformed; and that this natural process results in the best death for the individual. This can be understood through the recognition that all individuals will die from an illness that is terminal (unless they die through an accident). Nowadays, illness' that once may have been terminal and accompanied by a relatively painless death are treated and individuals recover only to be struck with another, arguably, more painful and debilitating illness that will then result in their death. Callahan's view is that in some cases the treatment of the first illness deformed the process of dying which means it may have been more acceptable to allow the first illness to lead to death. He contends that the first death may have been better for the patient in a way that outweighs the value of any extra time lived (if the patient had died the second death).⁸¹

⁸⁰ D Gracia, "Palliative Care and the Historical Background," in *The Ethics of Palliative Care*, ed. D. Clark (Open University Press, 2002), pp. 19-33

⁸¹ Callahan, *The Troubled Dream of Life: Living With Mortality*, p. 181

Secondly, 'death is acceptable when there is a good fit between the biological inevitability of death in general and the particular timing and circumstances of that death in the life of an individual...it does not occur significantly earlier than is biologically necessary'. 'Significantly earlier than is biologically necessary' refers to the idea that the human lifecycle contains a range of possibilities (rather than a specific amount).⁸² If we die without reaching this range of possibility we will feel a sense of loss. However, if we have lived to fulfill the range of possibilities of the human lifecycle (even if we are in the lower end of the range) we should not feel that we have been deprived. A person who dies at age seventy may be considered unlucky because she passed away in 'early old age' as opposed to 'later old age' but one would not think that her life has been 'cut short', even if her death follows a decision to withdraw or withhold medical treatment.⁸³ According to Callahan:

'It would be strange to think of a death at age sixty as comparable in its tragedy and unacceptability to the death of a child. The reason for the difference is evident; sixty years is a full, although not necessarily a totally full, life cycle. It is sufficient time to accomplish most of what can be accomplished in a typical life, although more might be accomplished by a particular individual.'⁸⁴

The death of a child would be a poor fit with the timing that is biologically normal. This means that the child's death would not be acceptable, whereas if a person dies after living a full life this would be acceptable.

Callahan uses the 'historical mourning test' as a further criteria to determine if a death is acceptable. This involves imagining how people would have reacted to the death if it had occurred a hundred and twenty years ago. Back then, deaths of the elderly were not considered to be tragic; rather they were 'accepted as the ordinary way in which a person in that state dies', and 'understood as a blessing, a relief and a release'.⁸⁵ For example, in the case of an individual in a retirement home with a degenerative disease who had been unable to communicate with other individuals for a number of years,

⁸² The notion of the human lifecycle containing a range of possibilities corresponds closely with Daniels' notion of the normal opportunity range.

⁸³ Callahan, *The Troubled Dream of Life: Living With Mortality*. p. 181

⁸⁴ *Ibid.* p. 181

⁸⁵ *Ibid.* p. 183

the historical mourning test would show that her death, when it did occur, would be acceptable. This is because in the past her death would have been accepted as a blessing. Callahan maintains that this historical judgment still applies today, especially when we are trying to do what is best for the patient. He argues that prolonging life is not always the best thing for the individual: 'I [Callahan] contend that the person living in the earlier time was more fortunate, when there was no possible temptation to extend life'. In the above example the death occurred within the normal biological range of our inescapable death.⁸⁶

A death is acceptable when the process of dying is not deformed, when the death did not occur earlier than was biologically necessary, and when the historical mourning test shows that the death would not have been a tragedy. If medical resources were used to prolong the death of the individual, these would be unwarranted, as they would not benefit the patient.

4.2 Callahan's Application of the Prudential Lifespan Account

Let us now review how Callahan's ideas about a good death relate to Daniels' Prudential Lifespan Account. Callahan believes that society has moved away from the historical tame death to a wild death.⁸⁷ Medicine, he argues, has lost the ability to recognise that point in life when it is time for a person to prepare for death, say their goodbyes and pass away. A shared understanding of the conditions that result in an acceptable death would help guide hypothetical deliberators in the way they would allocate healthcare resources, especially at the end-of-life.

According to Callahan, a good death, as part of a complete life, would not involve a ceaseless fight to keep death at bay. This position aligns with Daniels' view that people are more concerned with preserving their chances of having the 'normal range of opportunities' than extending their lives. What Callahan is adding to Daniels is a further analysis of why this should be the case. This analysis goes beyond a straightforward consideration of resource allocation, and focuses also on the implications of our mortality for the purpose of developing a deeper understanding of

⁸⁶ Ibid. p. 183

⁸⁷ Note, 'tame' death is used interchangeably with 'good' death.

how our healthcare resources can be meaningfully used. Thus, his argument is not simply that older people should be denied life-extending treatment because they have had a greater 'share' of life (and healthcare resources) than younger people. Rather, it is that providing these resources to the elderly is, in many cases, not worthwhile because they have reached the end of their natural lifespan and there are no further 'opportunities' to be had. Callahan believes that this shared understanding of what is a worthwhile use of resources would be arrived at by the hypothetical deliberators in the original position, once they had the understanding of an acceptable death described above.⁸⁸

A major implication of Callahan's view is that it presents society with a duty to protect citizens from the harms of a 'wild death', and increase their chances of a 'good death'. This requires the general recognition of death as necessary and acceptable. Death is not to be 'fought' in the way that it often is and aggressive medical technology and treatments should not be administered in harmful ways. In order for this to occur, Callahan argues, we will have to set limits on the healthcare that we provide to our elderly citizens.

In order to set limits on healthcare, Callahan believes that two additions need to be made to the Prudential Lifespan Account. Firstly, he argues that in order to ensure members of society are likely to experience an acceptable death we need to agree on an 'ideal' of old age that we can accept as the base standard that individuals should live to reach. This ideal will represent that point in individual lives from which death will no longer be resisted. This concept of an ideal of old age should offer resistance to an unlimited claim on medical resources in the name of medical need. It should also aim to help everyone achieve a minimally adequate standard. The ideal of old age will form the upper limit of the normal opportunity range and is necessary because improving medical technology has made it difficult to define what a normal

⁸⁸ Note, the social contract theory underpinning Daniels' position remains relevant to Callahan in that it provides the normative mechanism for developing a shared understanding of 'the good'. Meta-ethically speaking, Callahan is identified as a 'communitarian', which means, broadly speaking, that he believes that an understanding of the good is derived from 'community' agreement (and generally focuses on the relational aspects of the human life). I will not explore that relationship between social contract theory and classic liberalism here.

lifespan encompasses. Secondly, the normal opportunity range (and the ideal of old age) should not take into account technological advances. The creation of a technological intervention that has the potential to increase the lifespan of individuals does not mean that we ought to use it (as prolonging a person's life may 'deform' his or her death). This should increase the likelihood of a good death for citizens and decrease temptation for technological brinkmanship.

In summary, the ideal of old age should be 'socially adequate and generally acceptable...morally defensible for policy purposes'. However, it should not reflect technological advances that would have greatly increased life expectancy within that society. The addition of these two factors to the normal opportunity range makes the Prudential Lifespan Account 'better serve my [Callahan's] purposes'. This is because they help establish the upper age from which limits on healthcare will be implemented. These additions make the normal opportunity range more relevant in setting limits on care for elderly citizens.⁸⁹

The paradigm shift towards a shared understanding of a good death, along with the additions to the Prudential Lifespan Account outlined above, result in the formation of the following goal for medical care for the elderly: to bring all individuals up to the 'ideal' of old age which defines the upper limit of the normal opportunity range.⁹⁰ This clearly defines the parts of the lifecycle that should be protected through our healthcare systems *viz.* that which is included within the normal opportunity range throughout each life stage up to the ideal of old age. Beyond the normal opportunity range, hypothetical deliberators with their thoughts 'deepened' via Callahan's discussion of what constitutes a good death, would recognise the importance of allocating resources in a meaningful way. This will mean that they will cap the treatment made available to elderly individuals (because in some cases, treatment will not result in any further opportunities being made available to the individual concerned).

⁸⁹ Callahan, *Setting Limits: Medical Goals in an Ageing Society*. pp. 137-8

⁹⁰ This is because in Callahan's view, the treatment made available to the elderly directly influences the type of death (tame/wild) they are likely to experience.

At a governmental level, under the Prudential Lifespan Account, there is an obligation to offer life-prolonging treatments to citizens to provide them with opportunity to reach the next stage of life. This is because the goal of medical care is to help them to reach the ideal of old age. Therefore, if a person has not yet reached the ideal of old age a medical professional is obligated to intervene so as to help the individual reach it. However, if a person has reached the ideal of old age there will no longer be an obligation to provide life-prolonging care. In this view ‘our common social obligation to the elderly is to help them live out a natural life span; that is, the government is obliged to provide deliberately life-extending healthcare only to the age which it is necessary to achieve that goal.’⁹¹ Nonetheless, this does not mean that individuals should be denied all forms of medical care once they reached the ideal of old age. It is only those interventions that are classified as ‘life-prolonging’ that he believes should no longer be provided. A large number of treatments will be still utilized, *viz.* those with the intent of making the individual as comfortable as possible. This includes basic nursing care (which many regard as important not just for the purpose of maintaining comfort but also for maintaining dignity). So, it is not that healthcare should cease completely once the ideal of old age is reached but rather the goal of healthcare is changed. The goal is no longer to extend life and fight death, rather it is to provide treatments that will relieve suffering for that individual.⁹²

In order to apply these principles in practice we will need an objective standard that could be used to define the point at which the ‘ideal’ of old age had been reached. This is important because it is the point from which limits on life-prolonging care will be implemented. Callahan discusses three options for this objective standard: need, chronological age or biographical age. I will discuss each of these in the following sections.

4.2.1 *Need-based standard*

A need is something necessary for humans to live a ‘healthy’ life.⁹³ Callahan does not use need as a measure of the ideal of old age for a number of reasons: primarily, the

⁹¹ Note, natural lifespan refers to reaching the ideal of old age.

⁹² Callahan, *Setting Limits: Medical Goals in an Ageing Society*. p. 138

⁹³ *Ibid.* pp. 167-69. Evans has also written on the use of a needs based standard in medical care. For him, the main problem lies with the identification and aggregation of disparate goods. How can we, he

concept of need is relatively subjective and is influenced by many factors. Moreover, the ideal of old age is meant to represent the upper limit of the normal opportunity range. A simple measure of 'need', however defined, gives no reflection of how much of the normal opportunity range the individual has had the opportunity to fulfill. Therefore, concludes Callahan, need is not an appropriate measure of the ideal of old age.⁹⁴

Rather than using need as a measure of the ideal of old age, Callahan instead looks to the use of age to measure the ideal of old age. He writes: 'despite its [the use of age] widespread, almost universal rejection, I believe that an age-based standard for the termination of life-extending measures would be legitimate.'⁹⁵ Callahan outlines two different ways age could be used as a criteria for setting limits. I will discuss these in the following sections.

4.2.2 *Chronological age as a medical standard*

A medical standard is any factor that is medically relevant, such as weight, blood pressure or white cell count. If age were to be used as a medical standard within a clinical encounter this would involve 'treating age as if it were the equivalent of other physical characteristics of a patient'. As patients grow older in general they are more likely to suffer from medically related difficulties, such as hypertension or taking longer to heal after surgery. In addition, the incidence of most medical conditions goes up, particularly cancer, ischemic heart disease, chronic obstructive respiratory disease, chronic renal disease and also osteoarthritis. Older patients are often more sensitive to medication because they metabolize and excrete drugs more slowly. Most drugs are still effective in elderly patients but they often need to be given in a smaller dose than the dose given to a younger person with normal physiological parameters. However, the relationship between chronological age and these factors is a correlation

questions, develop an equitable way to compare all medical conditions using one common measure? This objection to a needs-based standard can be applied to any theory where disparate goods are aggregated, for example, Mill's utilitarianism. However, the fact this is a relatively common problem for many theories does not mitigate its pertinence. Evans states that the goods that would be weighed in a 'common balance' through a need-based standard are simply incommensurable. In: D. Evans, *Values in Medicine: what are we really doing to our patients?* (New York: Routledge-Cavendish Publishers, 2008). p. 72

⁹⁴ Callahan, *Setting Limits: Medical Goals in an Ageing Society*. p. 134

⁹⁵ *Ibid.* p. 116

only (rather than a causal relationship). The chronological age itself does not cause these factors, therefore chronological age is not, in itself, medically relevant. Being seventy-five, for example, does not cause kidney failure or a myocardial infarction. Rather, we are more likely to see these conditions in patients who have a greater chronological age, but their chronological age will not tell us anything about their actual health status. If chronological age were to be used it would be acting as a proxy for those factors that are more likely to be seen as a patient grows older rather than a measure that has merit in its own right. Given these points, the use of chronological age will not be the best measure of the ideal of old age. While it does provide an indication (based on statistical probability) of the degree to which the standard of the normal opportunity range has been reached, by itself, chronological age does not tell us anything relevant about the health status of an individual.⁹⁶

4.2.3 Biographical age standard

A biography is a life story, and the ‘biographical age standard’ – according to Callahan – is an assessment of the age of the person within the overall ‘story’ of her life. It is an assessment of the age of the person considered not simply in terms of the number of years they have been alive but as a ‘whole person’. In deploying this standard, chronological age would be considered along with their ‘biography’ or individual situation. In Callahan’s view, an understanding of the biography of an individual is possible because of the ‘age-associated’ traits that people demonstrate at different stages of life. These traits are not clear-cut, yet they are something that all individuals have a general understanding of. For example, we find it relatively easy to discern if an individual is young or old through simply observing them. Callahan states that it is other people’s recognition of our own age-associated traits that result in us ‘growing old in other people’s eyes’ and that over time ‘slowly we start to share their judgment’. As we start to share the view of other individuals, we will become old in our biography and begin to acknowledge that our death is approaching. This means that clinicians would be able to take into account:

‘Not just what chronological age may tell us about the state of a person’s body... but also what it morally and psychologically signifies for a person to have an old rather

⁹⁶ Ibid. pp. 164-65

than a young body, or what it means for a person to be old rather than young when considering the prospect of a painful treatment.’⁹⁷

These two factors would combine to form, for the clinician, a picture of how much life the individual has left to live. If chronological age were to be used in isolation it would not tell us enough about the patient to give us a full understanding of where they had come to in their life story. On the other hand, if we were to combine it with the biography of the patient, the biographical age standard becomes a:

‘...category of evaluation in its own right, something reasonable and proper to wonder and worry about. It bears not only on physical characteristics, but on a person’s self-understanding, as something intrinsic to a person’s individuality and life story.’⁹⁸

Using both chronological age combined with the biography of a person will reflect both how much of the spectrum of age specific normal opportunity ranges an individual has had the chance to fulfill, and will also give an indication of where an individual is ‘at’ within their own life story. This will allow the doctor, at the appropriate time, to shift the goal of medical care from fighting death to relieving suffering. The measure of the biographical age standard has the broadest scope and is most appropriate for determining whether a patient has reached the ‘ideal of old age’.⁹⁹

It is interesting to note that when compared to the other theories I have discussed so far, this notion of biographical age is unique to Callahan. Harris, Giordano and Persad use chronological age in their discussion of resource allocation. As we looked for a deeper understanding of how Persad’s theory would work in practice it seemed that the use of chronological age was, in itself, too simplistic. Daniels does not use chronological age but rather the notion of ‘species specific functioning’ and the normal opportunity range in his discussions surrounding age-based allocation. However, Daniels does not clearly define these terms, nor does he describe how we could use them in practice. In order to apply Daniels’ Prudential Lifespan Account,

⁹⁷ Ibid. p. 171

⁹⁸ Ibid. p. 171

⁹⁹ Ibid. pp. 166-67, 170-71

Callahan uses biographical age, which gives a fuller understanding of the patient than the use of chronological age alone. Broadly speaking, there is resistance to the idea of using ‘black and white’ measures such as chronological age. Part of Callahan’s claim is that this resistance occurs these measures do not take account of the way people age differently. For example, some individuals can remain perfectly fit and healthy, exercising daily and involved in their community at, say, age eighty-five, while some individuals are bed-bound from age sixty-five and do not have the physical capabilities to exercise or even move around much at all. The notion of biographical age is flexible in ways that a pure chronological age measure is not. It involves the clinical judgment of the doctor and so moves away from objective cut-offs as it is up to the doctor to make a judgment about where the patient is ‘at’ in their life. In the next section I will describe how Callahan applies this notion of biographical age to the clinical setting.

4.3 Allocation within the clinical encounter

According to Callahan, the goal of medical care is to protect the normal opportunity range. The upper limit of this is the ideal of old age, as measured by the biographical age standard. As I outlined previously, in order to achieve this, once an individual reaches the ideal of old age, treatment will no longer be oriented toward resisting death. Rather treatment will have the goal of preventing or reducing suffering where possible (through nursing care, pain relief and drugs). These principles guide clinicians in the treatment of individuals who have reached the ideal of old age. However, in order to see how they would work in practice we need to further consider how a doctor could apply them in a clinical situation. Callahan proposes this could be done through classifying the physical and mental status of the patient and their quality of life. These classifications will allow an assignment of the level of care a patient will receive. In Figure One on the next page I have outlined these classifications:¹⁰⁰

¹⁰⁰ Ibid. p. 171

4.3.1 Classifications

Table 1 Daniel Callahan's classifications¹⁰¹

<p>A. Physical and mental status</p> <ol style="list-style-type: none">1. Patients with brain death2. Patients in a persistent vegetative state3. Patients who are severely demented4. Patients with mild to moderate impairment of competence (or fluctuating competence)5. Severely ill, mentally alert patients6. Physically frail, mentally alert patients7. Physically vigorous, mentally alert patients
<p>B. Levels of care</p> <ol style="list-style-type: none">1. Emergency lifesaving interventions (example, CPR)2. Intensive care and advanced life support (examples, intensive care units, and respirators)3. General medical care (examples, antibiotics, surgery, cancer chemotherapy, artificial hydration and nutrition)4. General nursing care for comfort and palliation
<p>C. The quality of life of the patient.</p> <ol style="list-style-type: none">1. Criteria of quality of life: capacity to think, feel, interact with others2. Impediments to quality: severe pain and suffering (or effects of medication to relieve them), and any other condition that thwarts capacity to think, feel and interact with others.

¹⁰¹ Ibid. pp. 181-2

This classification system is meant for the elderly only and does not apply to the young.¹⁰² It is in this sense that chronological age remains a relevant factor. Callahan justifies this through saying the elderly have already had the chance to live out a full life, whereas the young have not. Therefore, it is not unfair to have different criteria for the young and the old. These categories allow the physician to measure as objectively as possible the biographical age standard. A chronological age will be chosen to represent the age from which an individual will move into this classification system for care. Individual patients are then grouped under these seven categories of physical and mental status so as to form a picture of their 'biographical age'. Following this we can then look at the recommended level of care for an individual in each of these groups. Callahan's recommendations for treatments of elderly individuals in each physical and mental status category are as follows:

Level 1: In the case of a patient with brain death no further medical care of any kind is called for. This is justified because 'all potential for being a person is irrevocably lost'. The brain has been irreversibly damaged and there is no voluntary or involuntary control of the brain remaining that will enable life-sustaining functions to be carried out. In Callahan's view 'only a pronouncement of death is in order.' Currently, after brain death has been declared the organs of the patient are legally allowed to be removed for organ donation (only through prior consent of the patient and consent of the family).¹⁰³

Level 2: A person who is in a persistent vegetative state is more problematic. A vegetative state refers to a patient who has been severely brain damaged and is in a state of partial arousal rather than true awareness. Once four weeks in this condition have passed, this is referred to as a persistent vegetative state. These individuals have 'lost all capacities for personhood, though clinical death has not occurred'. Assuming they have been correctly diagnosed, these individuals should receive care at level four only (general nursing care for comfort and palliation). This will ensure that the dignity of the patient is maintained and that suffering is minimized. Artificial

¹⁰² This classification system does not preclude withdrawing or withholding treatments from younger people who will not benefit from those treatments. However, this system is not designed to guide clinicians in the allocation of interventions to young individuals.

¹⁰³ Callahan, *Setting Limits: Medical Goals in an Ageing Society*, p. 182

nutrition or hydration will be terminated because these interventions ‘serve no purpose and do no honor to the body or to the memory of the person who once inhabited the body’. A consideration of the biographical age of a person in this stage would indicate that the patient would be unable to move any closer to the ideal of old age. This means that medical care would no longer be oriented towards resisting death.¹⁰⁴

Level 3: Dementia refers to a serious loss in global cognitive ability in an individual who was previously unimpaired. The loss in cognitive ability exceeds that which is normally seen in ageing. These patients exhibit a reduced capacity to interact with other human beings and ‘the prognosis for relief from severe dementia is poor at best in the old, and in irreversible cases nonexistent’. Therefore, these individuals will have come as close to the ideal of old age as they will be able to. In Callahan’s view in patients with severe dementia ‘...the death of the person, if not the body, is underway and need not be resisted’. Hence, healthcare will be provided only at level four which is general nursing care for comfort and palliation. However, these individuals still have the capacity to experience emotion so care at level three should also be provided, but with the goal of reducing suffering not to resist death.¹⁰⁵

Level 4: Patients with mild to moderate impairment of competence (or fluctuating competence) can experience emotion and can interact with human beings. However, if they have reached the ideal of old age (like all hypothetical individuals we are discussing here) we will not aggressively resist their death, regardless of the cost of treatment (it may be cheap to treat their condition – though this is not a relevant concern). This means that care at levels one and two would not be provided (as they can only be administered with the goal of resisting death) whereas care at level three would be provided with the goal of reducing suffering. Finally, these individuals would receive care at level four – general nursing care in order to provide comfort and palliation.

¹⁰⁴ Ibid. p. 182

¹⁰⁵ In this case, the provision of artificial nutrition and hydration raises some problems. There is currently some controversy surrounding the classification of artificial nutrition as basic nursing care or a form of medical care. Depending on which definition we chose to accept this would change how we would administer this to our patient. In: *ibid.* p. 183

Level 5: Severely ill, mentally alert patients will receive care at level four. They will also receive care at level three if it is likely that it would reduce their individual suffering. Callahan believes that severe illness, especially if it is likely to be terminal without receiving aggressive intervention ‘should preclude emergency lifesaving interventions and intensive care and advanced life support (levels one and two)’.¹⁰⁶

Level 6: Physically frail, mentally alert patients would be eligible for care at levels three and four. In some cases they would also be given care at level one (emergency lifesaving interventions). However, these people would not be given care at level two because ‘extended intensive care and advanced life support would be unwarranted at public expense, and an unjustifiable effort to extend life’. Hence, fit elderly individuals would be allocated healthcare not only to improve their quality of life (through providing care that will decrease suffering and provide them with dignity) but they would also be allocated emergency lifesaving interventions. This is because there is a high probability they would recover from the treatment and that it would not decrease their likelihood of having a good death.¹⁰⁷

Level 7: Physically vigorous, mentally alert patients would be given care at each of the four levels, despite the fact that they had the opportunity to live a full life. It is only when an individual moves into category one through six that they will have their treatment limited. This is justified through the following reasoning ‘I do not think that anyone would find it tolerable to allow the healthy person to be denied lifesaving care’. ‘One incident’ he goes on to note, ‘does not prove that death or precipitous decline is on its way’.¹⁰⁸

It may seem that this conclusion sits oddly with the Prudential Lifespan Account based, as it is, in a theory of justice. One might think that claims of justice should override concerns about what one finds to be tolerable. This perhaps indicates a tension between the needs of justice and the interests of the individual patient. This is

¹⁰⁶ Ibid. p. 183

¹⁰⁷ Ibid. p. 184

¹⁰⁸ Ibid. p. 184

a tension that has not been fully worked out in Callahan's argument. I will discuss this further in Chapter Five.

Callahan's system, as outlined above, shows us that chronological age, in most cases, is going to be significant because we can take it as a broad rule that if a person is over the age of seventy-five (or whatever age is taken to be the chronological component of the biographical age standard for that particular society) these categories will be applied. However, if a person is younger than seventy-five these categories will not be applied i.e. if a thirty-year-old died of cancer they would not have reached the ideal of old age. These principles are an attempt to guide clinical application of the notion of an acceptable death and the corresponding claim that people (and society by extension) are primarily interested in having the chance to realise opportunities, under the recognition that in some clinical situations there are no opportunities left to be had. For example, for an elderly individual in a vegetative state, there are very minimal opportunities left to be had and therefore, in Callahan's view, there is no duty remaining to treat that patient. However, in the case of a fit and healthy elderly individual, there may be more opportunities to be had and so treatment should be provided.

4.3.2 The rights of patients

It may be argued that denying life-extending treatments to patients is a breach of their rights. However, we must remember that the notion of biographical age includes where the patient is 'at' in their life story. It is, according to Callahan, relatively unlikely an individual will desire life-prolonging care whilst displaying age-associated traits (both physical and emotional) that indicate that the time has come to orient the patient's care towards death. This is because with the emergence of age-associated traits, an acceptance of death and mortality usually occurs and hence the patient becomes less likely to resist death. This means we see a phenomena where the elderly no longer want to live for as many years as possible, rather they want to enjoy as many *good* years as possible. However, if an impasse arises between the doctor and the patient, we must consider what the patient is entitled to under their 'patient

rights', and particularly their right to autonomy.¹⁰⁹ In Callahan's view the rights of patients to demand medical interventions (their right to autonomy) extend only so far as the patients requests align with the goals of medicine. According to him, the goal of medicine is to help all individuals reach the ideal of old age. From this point it is acceptable to limit treatment to the relief of suffering. If a patient demands more than this (demands life-prolonging care once they have reached the ideal of old age) they are making demands outside of their patient rights. According to Callahan, if these principles were accepted and applied in mainstream medicine, this would greatly increase the likelihood of good years for the elderly and would result in an acceptance within the medical community that prolonging life past this point would be unlikely to result in more good years.

4.4 Callahan and the problem of the ageing population

Callahan tells us what it means to protect the normal opportunity range. Those persons who are over a certain chronological age are likely to be moving to a state where opportunities are no longer available. This implies that we should be careful in scrutinizing which treatments will be made available. However, the opportunities left to be had by different individuals are not hard and fast, and so Callahan offers a system of categorization to help clinicians determine where patients are at in their life story and the treatments that should be made available to them. These principles reflect the position that if there are no opportunities left to be had, there is no duty to treat the individual with any goal other than relief of suffering (and preservation of dignity).

For Callahan, this system of healthcare resource allocation supports what is in the best interests of the elderly, and guides us to use resources in a way that is consistent with the goals of medicine. It is worth noting that Callahan's proposals broadly align with the goals of contemporary palliative care, and these goals are accepted by many doctors currently practicing in New Zealand and elsewhere.¹¹⁰ Callahan's principles of limit setting can be seen echoed in, for example, the principles of the Liverpool

¹⁰⁹ A reference to patient rights often refers to the Patients' Bill of Rights. This is a list of guarantees for those receiving medical care. Typically this guarantees information, fair treatment and autonomy over medical decisions.

¹¹⁰ Morgan and Simmons, *Health Cheque: The Truth We Should All Know About New Zealand's Public Health System*. p. 138

Care Pathway, which has been adopted in a number of countries including New Zealand.¹¹¹ Callahan's principles are based on the measure of biographical age, which encourages clinicians to consider the life of the individual patient and what is best for the patient. Whilst they are perhaps more rigid than the Liverpool Care Pathway, they have the same object – to recognise that time in the life of an individual when life can no longer be prolonged in a way that is meaningful, and hence, when treatment should be adjusted accordingly. If this comparison is accurate, then we have to a certain extent adopted Callahan's position in medical care today.

While Callahan's principles arguably reflect what is best for individual patients at the end of their lives, it is not clear that they will fully address the problems of the ageing population that I outlined in Chapter One. A thorough application of Callahan's ideas would relieve some of these pressures. It would help us to adjust our expectations of healthcare and guide clinicians in their use of medical technology particularly at the end-of-life. This would reduce the costs of end-of-life care to some extent, as elderly people would not be given unnecessary treatment and healthcare resources would only be used in ways that were genuinely helpful. People would not be kept alive longer than they should. However, this alone would not address the central problem related to the changing ratio of older to younger people: the decrease in the number of workers contributing to the overall GDP and tax intake relative to the number of dependents who are not productive in the same ways. Older people generally need greater levels of care, especially rest home and nursing care. Callahan does not propose that we limit these forms of care. Thus, even while following Callahan's principles the overall costs of healthcare will still increase dramatically as the population ages (while the relative tax intake decreases).

¹¹¹ The Liverpool Care Pathway is a care pathway initially developed in the UK. It outlines palliative care options for patients in their final days or hours of life. It was developed to guide healthcare professionals in their provision of end-of-life care in matters such as discontinuation of treatment and comfort measures. It has an emphasis on not only the physical aspects of an individual but also the psychological, spiritual and family aspects. Once an individual is placed on the Liverpool Care Pathway the focus of their treatment plan becomes the provision of care and comfort during their final phases of life, rather than cure. In: Z. Kmietowicz, "Health professionals defend the Liverpool care pathway," *British Medical Journal* 355(2012).

Given that Callahan's extension of the Prudential Lifespan Account does not fully address the problems of the ageing population, it may be asked whether the more radical option of a chronological age based rationing policy should be introduced in order to protect the normal opportunity range for all generations. In the next chapter I will show why such a policy should not be implemented, and in particular why it would be contrary to the principles of justice. In the final chapter I will outline some alternative approaches that are in my view consistent with Daniels' and Callahan's aims.

CHAPTER 5: WHY AGE-BASED RATIONING OUGHT NOT TO BE USED TO SOLVE THE CHALLENGES FACING OUR HEALTHCARE SECTOR

In New Zealand the healthcare sector is facing challenges related to the ‘ageing population’. In Chapter One I outlined these changing demographics along with the increased expectations of the healthcare sector, the increasing life expectancy of New Zealanders and new advances in expensive medical technology. All of these factors are increasing the pressures (financial and otherwise) on our healthcare system. Similar trends are also seen in overseas countries, and there have been calls – some of which I outlined in Chapter Two – to ration healthcare resources to the elderly in order to try to contain healthcare costs. The main question I have discussed throughout this thesis is whether age-based rationing can be justified as a response to these challenges.

In Chapter Two I argued that the basic notion of age-based rationing is theoretically justifiable, and that age-based healthcare resource allocation would not necessarily devalue the elderly. If the policies were applied ‘consistently’ over the lifetime of all citizens, the allocation policy could be seen as ‘just’ because all individuals would be equally affected. In the Chapter Three I described Norman Daniels’ Prudential Lifespan Account, which is grounded in a Rawlsian social contract. This is designed to give all citizens the best possible chance of living a ‘full life’ through allocating resources to protect the ‘normal opportunity range’. The implication of this theory is that in situations where two relatively similar patients needed the same resource, the younger individual would have a greater claim to the resource because they would have experienced less of the normal opportunity range. In Chapter Four, I outlined Daniel Callahan’s practical application of the Prudential Lifespan Account, which is focused on what it means to live and die well. Callahan offers a set of principles aimed at ensuring that healthcare resources are used in ways that are worthwhile both from the perspective of the patient and society, while also limiting how much could be reasonably spent on an individual patient. Though this was presented as a

rationing argument based around our collective interests, its conclusions are directed at treatment decisions concerning individual patients. I therefore concluded that Callahan's position only offers a partial solution to the pressures described in Chapter One. It offers guidance as to what we should expect from medical care and how we should use expensive medical technologies, particularly toward the end-of-life. In this way it will contain some of the costs associated with end-of-life care. However, Callahan's principles do not provide guidance for a society where the challenges stem from a changing ratio of older to younger people. Even if the end-of-life care of each patient costs less we will still have a far greater proportion of elderly requiring end-of-life care, with a smaller working population paying taxes and hence a smaller pool of money to meet a greater need for care. In addition to this, Callahan does not propose any denial of rest home or basic nursing care both of which make up a large proportion of costs of end-of-life care. This means that while his principles would result in some improvements, they would not provide a solution to challenges of this magnitude and would not ensure that resources were distributed fairly between generations (which, following Daniels, means protecting the normal opportunity range for all members of society).

Given that Callahan's theory does not guide us towards a just response to the pressures facing us through the ageing population problem it seems that we are locked into a situation where younger generations will simply have less opportunity, because of what must be spent to meet the needs of the older population. Faced with this evidently unjust predicament it might be wondered whether a more radical solution is needed. One option that has not yet been properly considered is to adopt a straightforward chronological age cut-off for healthcare eligibility. This could mean, for instance, suspending all publicly funded healthcare for those over a certain age, or perhaps phasing out entitlement in stages as a person reached certain age thresholds. In this chapter I present four reasons why this approach should not be taken. Such a response would, in my view, be contrary to the principles underpinning the Prudential Lifespan Account, and also other established medical values. In the next chapter I consider some alternative responses, which are in keeping with this conception of justice.

The Prudential Lifespan Account requires us to protect the normal opportunity range. Older individuals have had their share of opportunity and yet will, on average, consume a large amount of healthcare resources towards the end of their lives. Overseas studies have shown that, on average, an individual will receive 25% of their total healthcare spending in the final two years of their life.¹¹² This is a 480% increase in spending compared to the average annual spending per capita.¹¹³ New Zealand Treasury estimates that \$NZ10000 of public money is spent in the last year of a (non-disabled) person's life.¹¹⁴ One way to ensure we protect the normal opportunity range, when there is a large increase in the proportion of elderly with a decreased number of taxpayers, would be to cease providing publicly funded healthcare from a particular chronological age or to phase out entitlement to publicly funded healthcare in stages as a person reached certain age thresholds. I do not believe that either of these options should be implemented, and I will now explain why.

5.1 Justice versus duty of care

The physician's 'duty of care' has a long established place in medical ethics. It imposes a legal and moral obligation on physicians to adhere to a reasonable standard of care for all patients. Implicit in this is the idea that every individual has value and is deserving of care.¹¹⁵ Going back to the Hippocratic Oath (5th century BC)¹¹⁶ the tradition of medicine has acknowledged that the obligation of physicians is to the patient in front of them. However, a tension exists between this duty to care for individual patients and the duty of physicians to take account of wider social injustice. A number of ethicists have argued that the duty of care overrides the physician's duties to the wider population, and read the Oath as proposing a 'patient-centric'

¹¹² C. Weel and J. Michels, "Dying, not old age, to blame for costs of health care," *Lancet* 350(1997). Note, this article highlights the expense is incurred in dying not old age per se. However, most people die in old age, hence the expense of dying occurs most predominantly in older age groups.

¹¹³ Annual public spending on healthcare per capita was \$NZ2083 in 2004. In: Morgan and Simmons, *Health Cheque: The Truth We Should All Know About New Zealand's Public Health System*. p. 107

¹¹⁴ J. Bryant, "Population Ageing and Government Health Expenditures in New Zealand: 1951-2051," *New Zealand Treasury Working Paper* (2004).

¹¹⁵ This was the basic moral ideal appealed to by Giordano, whose argument was discussed in Chapter Two, whereby all individuals should be accorded equal worth or status, regardless of their race, gender or age. The same ideal is affirmed in Rawls' first principle, which states that all citizens are free and equal.

¹¹⁶ The Hippocratic Oath is a sacred promise historically sworn by physicians outlining the standards they would uphold in their medical practice. It is commonly believed to have been written by Hippocrates, who is often considered to be the father of western medicine, or by one of his students. In: M Steven, *The Hippocratic Oath and the Ethics of Medicine* (United States of America: Oxford University Press, 2004).

clinical ethic that supports the professional autonomy of doctors to act in the best interests of their patients.¹¹⁷ In this view, the physician's obligation to think about resource scarcity is secondary to their duty to act in the best interests of their patients. In order to clarify this apparent tension, I will briefly review the factors that doctors are typically expected to consider as they assess a patient for treatment.

Under the general duty of care doctors require strong reasons not to provide treatment to patients in need. Examples of reasons that are generally regarded as compelling include: when the treatment is of no benefit to the patient, when there is clearly no available resource, and finally when another patient clearly has a greater claim to the available resource. I will now outline each of these in turn.

Care may be denied to a patient when the care is deemed to be of no benefit to that patient. Although benefit is a difficult term to define precisely, this does not prevent it from being used as a guiding principle in health policy. Where more precision is required certain conceptual frameworks have been developed that encompass alternative notions of benefit, their implications and the types of services that could be considered to produce the conceived benefit.¹¹⁸ This idea of only providing treatment that is of benefit to the patient is echoed in Callahan's view that if there is no further opportunity that would be made available to a patient through treatment then that treatment should not be administered. Whilst Callahan is referring to elderly people who have reached the ideal of old age, the idea is applicable to everyone. No intervention should be administered where the 'burdens' of that treatment outweigh the 'benefit' of that treatment.

Interestingly, decisions to withhold treatment from patients can have unexpectedly beneficial results. A recent study looking at patients with metastatic non-small-cell lung cancer randomly assigned 151 participants into two groups: one received standard oncological care and the other had early palliative care integrated with their standard oncological care. Patients in the palliative care group often opted not to

¹¹⁷ Ibid.

¹¹⁸ J. Hurley et al., "Medical necessity, benefit and resource allocation in health care," *Journal of Health Services Research Policy* 2, no. 4 (1997).

receive potentially life prolonging care, and at twelve weeks they reported better quality of life, fewer depressive symptoms and surprisingly went on to survive longer than the patients who received standard oncological care alone.¹¹⁹ The standard oncological care group reported a more depressed mood, poorer quality of life and a shorter life expectancy. Furthermore, treatment in this group was more expensive than the group assigned to early palliative care.¹²⁰ If we generalize this principle to other health conditions it seems that, in some cases, as well as there being no benefit in providing an intervention to an individual, there may also be benefit in not providing the care. (It is also interesting to note that these findings seem to correspond with Callahan's claim that we are better off living with an acceptance of our mortality.)

Care may also not be provided to a patient if the resources are simply not available. For example, certain medical interventions are not available in some geographical areas. Similarly PHARMAC¹²¹ only funds certain pharmaceuticals. There are many situations where a physician may not have the means to provide treatment to a patient. In such situations the doctor must fully disclose the reasons they cannot administer the treatment and provide a recommendation to the patient as to what the best course of action is. This may be to seek treatment in another area or in the private sector. Or perhaps the doctor will recommend a different though still beneficial approach for which resources are available.

The lack of available resource is central to the problem of distributive justice, which underpins another potentially appropriate reason for not providing care to a patient in need. It is legitimate not to provide care to a patient if there is another patient that has a greater claim and there is not enough available to provide care to both. In such situations care should be provided to the patient (or patients) with the greater claim. It is true, of course, that comparisons between patients are often hard to make because there are so many different factors involved (both objective and subjective).

¹¹⁹ T. Smith et al., "American Society of Clinical Oncology Provisional Clinical Opinion: The integration of palliative care into standard oncology care," *Journal of Clinical Oncology* 30, no. 3 (2012).

¹²⁰ Ibid.

¹²¹ PHARMAC is New Zealand's pharmaceutical management agency.

Nevertheless, in so far as these difficulties can be overcome, considerations of justice can be decisive in determining whether or not a patient receives treatment.

Issues of distributive justice arise in healthcare in a variety of ways. In emergency situations the person with the greatest need (who is likely to benefit from the treatment) is treated first. For example, in the emergency department of a hospital if a patient has been waiting to be seen for, say, six hours and then new patients suddenly arrive who are in a critical condition, those patients will be given priority because they have a more urgent need for medical care. This basic idea of providing care to those most in need is reflected in Rawls' second fundamental principle of justice. This states that healthcare resources should be directed in such a way to help those individuals who are worst off.¹²²

Following Daniels' Prudential Lifespan Account, a patient could also be denied care on grounds of distributive justice if there was another person with equal need who was younger. This is the case in the example of Mr. X and Mrs. Y, both of whom suffer from kidney failure and require dialysis. However, only one dialysis machine is available. Mr. X is twenty-five and Mrs. Y is seventy-five and both of them will benefit in a similar way from treatment in terms of quality of life and both will respond equally well to the treatment. Mrs. X has already enjoyed a full life (i.e. she has achieved the normal opportunity range)¹²³ whereas Mr. Y has not. Therefore the dialysis should be given to Mr. Y. Justice shows us that the person who has had less of the normal opportunity range has priority in terms of a claim to healthcare resources, when making a straightforward comparison between two people who simultaneously require a non-divisible resource.

For elective procedures New Zealand has developed scoring tools called CPAC (Clinical Priority Assessment Criteria) for assessing patients' relative claims for particular treatments. Patients are ranked according to their scores and prioritized correspondingly. These tools are designed to ensure patients with the greatest need

¹²² See 'Broad application of the Rawlsian view', Chapter Three, p. 32.

¹²³ Assuming that the normal lifespan/life expectancy in this society was 75 years for a female.

and potential to benefit receive treatment first (though for practical purposes a threshold is often set whereby a patient is booked for care once they reach a particular score). Thus, the scoring tool provides a basis to deny care to certain patients because there is a clear understanding that someone needs it more.¹²⁴

I have described three ways in which distributive justice plays a role in clinical decision-making: in triage situations (where there is a clear-cut needs assessment), when making a straightforward comparison between two individuals (such as Mr. X. or Mrs. Y.), and when prioritising patients for elective procedures (where tools have been developed to make the needs assessment as objective and as transparent as possible). The question in regards the above proposal to cease providing care to older people in order to protect the ‘normal opportunity range’ for all citizens is whether the ‘Prudential Lifespan Account’ can act in the same kind of way in the reasoning of the individual clinician, and provide a strong enough reason to deny care to patients. This, I suggest, is unlikely for a number of reasons. Firstly, the comparisons involved are nothing like as clear-cut. Consider what it would mean for clinicians if they were instructed not to treat, say, bowel obstructions on patients over the age of seventy-five, even though they know the resources are available and the treatment is being provided to patients who are younger. The clinician has to face the patient and break the news to them that they cannot be provided with the care they require. If this were because the treatment would not benefit the patient, or because there was no available resource, or because there was another patient who needed it more, then this would be possible for the patient and the clinician to accept. Those are compelling reasons. However, denying beneficial treatment on the basis of the Prudential Lifespan Account is much more tenuous. Here the physician is being asked to deny a ‘concrete’ need for the sake of an abstract ideal. This makes it harder for the physician to see the ‘good’ in what she is doing (especially given the harm she is facing), and to know that she is doing the ‘right’ thing.

The problem described here indicates a general problem with using theoretical ideals in ethical reasoning, *viz.* that there is often uncertainty about how the ideal will ‘work

¹²⁴ See ‘Overt healthcare rationing in New Zealand’, Chapter One, p. 2.

out' as we attempt to make it 'reality'. The Prudential Lifespan Account involves comparing the 'normal opportunity range' for different groups of people within a society. There is a considerable 'gap' between a clinician's decision to treat or not treat a given patient and the degree of opportunity that will be provided to, say, a generation of children. If there is a connection then it involves a number of economic relations that we only partly understand (at best). I will discuss this issue of economic uncertainty and how it relates to the application of the Prudential Lifespan Account in the following section.

5.2 Economic uncertainty and healthcare allocation

The Prudential Lifespan Account shows us that all members of society should receive their share of the normal opportunity range. Denying care to the elderly is currently being considered as a way of achieving this. However, the justification for denying care depends on this proposed policy releasing funding to support other generations (i.e. protect the normal opportunity range for all of society) and the links between these particular decisions are fraught with uncertainty. From the perspective of the clinician there is no certainty that in not providing care to an older person she will in fact be protecting the normal opportunity range for other people. Consider the example of a patient with pneumonia who has reached the standard of the normal opportunity range. This particular patient would benefit from treatment with antibiotics. Antibiotics are relatively cheap, and in the case of this particular patient they will work effectively. They will only confer a small burden on the patient and will allow that patient to return home and enjoy more time with their family. This patient is, in theory, a member of that group of individuals who cost the healthcare system a large amount of money (the elderly). However, there is no guarantee that denying this patient antibiotics for their pneumonia will, in fact, achieve what justice requires i.e. that all members of society are provided with their fair share of opportunity, by, for example, providing adequate education to younger persons or better healthcare etc. The link between denying care to the patient and benefits being directed instead to other areas is highly complicated and debatable, and so should not be considered a sufficiently compelling reason to deny beneficial care to this patient.

The difficulty of applying a resource scarcity argument in clinical decisions can be shown through many examples, even examples within a contained unit. For instance, nowadays many mothers have elective caesarian sections because they believe that as it occurs in a highly controlled environment it will be safer for them and their baby. Elective caesarian sections require a large number of staff (for example, an anesthetist, anesthetist technician, nurses and other doctors), a surgical room and a longer recovery time of the mother.¹²⁵ This means that they are more costly than natural births, which (if they occur normally) can require only two staff members (sometimes even one). Some policy makers argue that a woman should only have a caesarian section when it is medically indicated, and that a woman should not be able to choose to have a procedure that is both expensive and, in their opinion, unnecessary. They believe that the money would be better spent elsewhere in the healthcare sector.¹²⁶ However, Francoise Baylis of Dalhousie University, a feminist bioethicist, argues against the economic justification underpinning this proposed policy.¹²⁷ She claims that caesarian sections would be cheaper overall because the complications that occur can be fixed easily and with relatively little cost. Natural births, on the other hand, are cheaper when they occur without complications but if complications do occur the costs can be very high. Baylis argues that if these costs are taken into account then denying elective caesarians is shown to be more expensive than allowing them. I am not concerned here with determining whether or not Baylis is correct; the point is simply that economic reasoning needs to be supported by adequate economic analysis, and, as this case illustrates, economic analyses can be contested. Comparing the cost of caring for the elderly with the costs of providing other social services aimed at preserving the 'normal opportunity range' is especially complicated, and there would be few clinicians or ethicists qualified to do so. This means that the clinician cannot know for sure that her concrete denial of care to one individual will result in the fulfillment of the abstract ideal, *viz.*, the protection of the normal opportunity range.

¹²⁵ D. Collard et al., "Elective Caesarean Section: Why women choose it and what nurses need to know," *Nursing For Women's Health* 12, no. 6 (2009); S. Cali and S. Kalaca, "Caesarean Section: a privilege or a necessity?," *Journal of Contraception and Reproductive Healthcare* (2004).

¹²⁶ Cali and Kalaca, "Caesarean Section: a privilege or a necessity?."

¹²⁷ She also argues that the policy would be paternalistic and undermine women's autonomy, however, I am not concerned with these issues here. In: F. Baylis, "Ethical considerations in prenatal surgical consultation," *Pediatric Surgery International* 15(1999).

5.3 Implications of age-based rationing policies

The economic uncertainties I have just outlined may be considered contingent or empirical i.e. as problems that we can overcome with the right amount of learning or study. On this basis it may be argued that the age cut-off would be acceptable as soon as we were sufficiently certain about the economic analysis. There are, however, deeper ethical considerations that need to be taken into account. In this section I will show why the proposal is contrary to the principles of justice underpinning the Prudential Lifespan Account.

To begin with, let us consider what is likely to happen if a policy of denying care to the elderly was adopted. In particular, let us consider how it would be received. Any person that did not understand the Prudential Lifespan Account and the economic analysis underpinning the denial of care (a substantial number) would most likely feel that patients were being devalued through being denied the care they required. This could have awful implications; a great number of staff at the healthcare institution would be angry at the suggestion that the elderly had a lesser claim to healthcare resources. Those who were not angry about such a policy, and who accepted it without an understanding of the Prudential Lifespan Account and the economics, would be implicitly taking the position that older persons *are* of less value. This too would be grounds for outrage for many people.

This predicted conflict may in itself be a strong enough reason not to implement the policy. However, if we recall that the Rawlsian method through which the Prudential Lifespan Account was developed rests on the notion of reflective equilibrium (the need for the theory to align in some way with our intuitions and vice versa), then we may think these reactions to be of deeper significance. If clinicians and other staff object so strongly to such a policy, perhaps this indicates that there is some deeper form of value attached to end-of-life care that the proposed policy overruns.

One way to articulate this deeper value is through Rawls' first principle, which requires all individuals to be regarded as free and equal. It may be that the age cut-off breaches this principle. This interpretation may be drawn via the link that is often

made between care (especially nursing care) and the recognition of worth, as I shall now explain.

5.3.1 *Respecting the humanity of individuals*

The imperative to relieve a person's suffering is often related to the value of the person as a 'human being'. Many treatments that are necessary for relief of suffering are also life-prolonging. This point was raised in a recent discussion I had with a surgeon at Dunedin Public Hospital. He stated:

'Many of the surgeries that I do on a daily basis are on patients over the age of 75. I do not feel that I could deny surgery to these individuals on the basis of age because if their [for example] bowel obstruction were left untreated this would confer a large burden of pain and suffering on the patient that would be unnecessary and preventable. These treatments are about respecting the humanity of other individuals and treating them in a humane way.'

The surgeon here is firstly pointing out that many of the procedures he provides both extend life and relieve suffering. This undercuts the possibility of limiting only life extending treatments. Secondly, he is linking the relief of suffering with the worth of the person. To not relieve suffering, he suggests, would be 'inhumane' i.e. it would deny her basic rights as a 'human being', and so denigrate her worth as a person. This point becomes particularly significant as we consider nursing care, which is very closely concerned with the relief of suffering.

5.3.2 *Nursing care*

Nursing care takes up 20% of our overall health budget and the New Zealand government spends over \$NZ1.5 billion annually on long term nursing care.¹²⁸ This means that nursing care can be focused on as a significant cost associated with end-of-life care. However, neither the Prudential Lifespan Account nor Callahan (nor any of the age-based rationing proposals I studied) proposed denying nursing care to the elderly.¹²⁹ It is worth examining why this is, and it seems reasonable to think that it is

¹²⁸ Morgan and Simmons, *Health Cheque: The Truth We Should All Know About New Zealand's Public Health System*. pp. 53-54.

¹²⁹ Note, not all societies accept the responsibility of providing nursing care to the elderly. R Veatch, "How Age Should Matter: Justice as the Basis for Limiting Care to the Elderly," in *A Companion to*

because the notion of human worth is often attached to reasons for providing nursing care to individuals. If we recall the pneumonia example that I outlined earlier in this chapter, it appears that we justify the denial of treatment on the grounds that it would not have benefitted the patient in any significant way. This is not the case with basic nursing care, which is about relieving suffering and making people comfortable. As implied in the quote above, relieving suffering is important in order to uphold the dignity and humanity of patients. Thus, to deny nursing care would be to deny the humanity of the patient.

When we move from considering individuals to implications for society then the situation looks even bleaker. Denying beneficial care to the elderly would involve the creation of a system separating members of society into two groups: one that would be provided with care and another that would not. The dangers of such a separation have been highlighted by a number of ethicists, and the position has even been compared to the ideological basis that led to the holocaust:

‘A ‘system’: a political, economic or cultural system – insinuates itself between myself and the other. If the other is excluded, it is the system that is doing the excluding, a system in which I participate because I must survive and against which I do not rebel because it cannot be changed...I start to view horror and my implication in it as normalcy.’¹³⁰

This highlights a danger not only to the elderly patient who may be denied beneficial healthcare (i.e. life-extending treatment when the elderly person is in the physical and mental state to benefit from the intervention) but also to healthcare professionals, whose professional ‘ethic’ is in part derived from the practice of those around them. If beneficial care was denied to members of society who did indeed need it, this may suggest to healthcare professionals that the ‘right’ thing to do was to deny the care.¹³¹ This in turn would incline society at large to adopt the same attitude, and as a

Bioethics Second Edition, ed. H Kuhse and P Singer (West Sussex: Wiley Blackwell Publishers, 2012). p. 442

¹³⁰ V Barnett, *Bystanders: conscience and complicity during the holocaust* (Westport: Praeger Publishers, 1999). In: E Loewy, "Age discrimination at its best: should chronological age be a prime factor in medical decision making?," *Journal of Healthcare Analysis* 13, no. 2 (2005). p. 115

¹³¹ Loewy, "Age discrimination at its best: should chronological age be a prime factor in medical decision making?." p. 115

consequence older people – all of us if we live to the expected age – would no longer be regarded as ‘equal’. Such a situation is totally contrary to the first principle of Rawls Theory of Justice, and so it is also contrary to the goals of the Prudential Lifespan Account. In this way the ethical basis of the policy completely collapses.

5.4 Conclusion

I have argued that a policy of denying beneficial care to persons over a certain chronological age is unacceptable. I began by showing how it would undermine the physician’s duty of care. I discussed how this problem is related to economic uncertainties inherent in the justice argument, and to the difficulty of separating treatments that extend life from those that relieve suffering (often a treatment that is necessary to relieve suffering will also extend the patient’s life). I then explained how denying beneficial care to persons over a certain chronological age would be contrary to Rawls’ first principle of justice, because it disrespects the humanity of those people denied care and results in a society in which certain demographic groups are regarded as having less value than others.¹³² This means that we must respond in a different way to the challenges of the ageing population in order to realise the goals of the Prudential Lifespan Account. I will outline some possible responses in the next chapter.

¹³² To this extent the objections raised by Giordano and the first objection raised by Harris are shown to be significant (see Chapter Two).

CHAPTER 6: ALTERNATIVE RESPONSES

I have shown that denying treatment to patients over a particular chronological age is unacceptable. However, the challenges our healthcare sector is facing will exacerbate resource scarcity and this needs to be addressed. Therefore, we must consider alternative ways of providing care for our elderly citizens that are sustainable for our economy and healthcare sector. In this chapter I will outline some possible approaches, some of which have already been taken up in policy or suggested in the literature, and link them with the theories of both Daniels and Callahan.

6.1 Rejecting the ‘lifeboat’ framework

The Prudential Lifespan Account is guided by principles of justice that assume we will not be able to meet all healthcare needs with our fixed amount of healthcare resources. However, not everyone agrees with this presumption. These people argue that resource scarcity would not exist in the population if the resources we have were shared more equally among members of society. Barnett, for example, states that when arguing with a base assumption of scarcity we are incorrectly assuming we are in a ‘lifeboat’ situation. In a lifeboat situation we would be forced to consider what we would do if we were on a lifeboat and had to decide who will be left on in order to survive i.e. we assume we have finite resources and we must decide who would receive the healthcare and hence who would survive. Barnett, however, states that ‘we are not even close to facing’ a lifeboat situation and that other responses must be considered before denying members of society beneficial care, such as raising taxes or the age of retirement.¹³³

Raising taxes or lowering the age of retirement are options for raising revenue to support the increasing need for healthcare, but I do not accept Barnett’s claim that resource scarcity does not exist. In gathering revenue to support healthcare, resources are being drawn from other sectors – there is not an unlimited amount of public money. Furthermore, raising tax is a highly contentious issue that involves a range of considerations, such as the effects on the overall productivity of the country, and what

¹³³ Barnett, *Bystanders: conscience and complicity during the holocaust*.

is a reasonable or fair amount of tax for a person or company to pay. Increasing the retirement age may potentially increase productivity (and decrease the welfare burden), so long as there are jobs available. Such questions are debated at a national level in almost all modern democracies, and it is beyond the scope of this thesis to offer an opinion. It is clear, however, that the solution to the challenges facing us is not as simple as, say, raising the tax rate.¹³⁴

In this chapter I will discuss possible alternative responses that I think will be acceptable to a range of political standpoints. These responses involve society as a whole taking more responsibility for the issues and giving more personal consideration to the question of what justice for the elderly involves. In the next section I will discuss alternative economic responses. Whereas Barnett's economic proposals focus on centralized government policy, mine focus instead on individual and family wealth.

6.2 Collective economic strategies

In recent years there has been strong debate surrounding whether New Zealanders save enough.¹³⁵ Research has shown 47.1% of New Zealanders have zero (or negative savings) and that a lot of the capital they accumulate is through capital gains in housing. Housing is a non-liquid asset, which means that the cash is not readily

¹³⁴ The Singaporean health system could be used as an interesting case example. Singapore has a corporate tax rate of 17% and a GST rate of 7% whereas New Zealand has a much higher corporate tax rate at 30% and a GST rate of 15%. Singapore spends only 4% of annual GDP on health while in New Zealand we spend 10.3% of our GDP on health. However, Singapore is recognised as having good health outcomes – in 2012 their average life expectancy at birth was 83.71 years whereas New Zealand's 2012 average life expectancy at birth was 80.71. Singapore also performs well in other indicators of health, such as low infant mortality rates and acceptable wait times for public healthcare treatment. A number of commentators have used these figures to say that an equitable health system does not necessarily require a high tax rate. See for example: P. Bapari, "Doing Business in Singapore vs New Zealand," Janus Corporate Solutions Limited.; J. Tucci, "The Singapore health system – achieving positive health outcomes with low expenditure," Towers Watson.; M. Barrientos and C. Soria, "New Zealand Life Expectancy at Birth " IndexMundi.; M. Barrientos and C. Soria, "Singapore Life Expectancy at Birth," IndexMundi. Of course, in comparing this system with New Zealand's health system, other variables should be taken into account. Firstly, it is unclear if the statistics apply to all residents in Singapore or just Singaporean citizens (they may have a large migrant labour force with lower access to healthcare). Furthermore, the health system in Singapore is not structured in a way that prioritises care to individuals who are worst off, for example, individuals who are disabled or who have chronic health conditions. This is likely to reduce the costs of healthcare overall and may affect of the life-expectancy statistics calculated. Lastly, consideration would have to given to other measures such as equity and access to healthcare in comparing the two systems.

¹³⁵ Saving is income not spent or deferred consumption.

available to be used if required.¹³⁶ The consensus is generally that as a society our lack of saving leaves us more vulnerable in times of crisis or if unexpected economic expenses arise, for example, healthcare costs in event of illness, or the costs of rebuilding homes following a natural disaster such as the devastating Christchurch Earthquake. In addition to this, it seems that the proportion of citizens who leave money to their children is declining. It appears that the saying ‘born with nothing, die with nothing’ has become a generation’s mantra, as retiring workers look to exhaust their wealth through the final years of their lives. If the majority of middle class citizens spend their money on, say, overseas cruises, rather than passing their wealth down between generations or putting money towards healthcare, then the nation’s wealth goes offshore to multinational corporations. This means their wealth is of no further benefit to their community or ‘family unit’.

Given that the pressures associated with the ageing population are going to affect all of society, it seems reasonable that we should respond collectively. This could simply mean that we all begin saving. The government in New Zealand has recently introduced an incentivized savings scheme called ‘KiwiSaver’, where if an individual contributes a certain amount of their income, the employer and government will also make a contribution. This is an example of one such collective response. There has been discussion recently of making this scheme mandatory so that all working persons are required to make a ‘KiwiSaver’ contribution from their earnings.¹³⁷ If all citizens retire with savings then both the individual and society will be better off. Superannuation currently does not provide enough money for what the average person would regard as a reasonable standard of life. People who retire with adequate savings will have an improved standard of living. This is likely to positively influence their health status and consequently reduce the amount they personally cost the government through public healthcare. This will in turn free up money for other sectors and mean that we are all better off with more robust families and communities.

¹³⁶ T. Le, J. Gibson, and S. Stillman, "Household Wealth and Saving in New Zealand: Evidence from the Longitudinal Survey of Family Income and Employment ", ed. Motu Economic and Public Policy Research (Wellington, 2010). p. 1, New Zealand Treasury, "A synopsis of theory and recent Treasury analysis on saving," ed. Treasury Report (2007).

¹³⁷ S. Robb, "Time to Tinker with KiwiSaver," *Sunday Star Times* 2008.

I suggest that a similar incentive scheme could be developed to help and support families in planning and caring for their elderly members. This would encourage care within the 'family unit', and may be impetus for a change in thinking about the way care of the elderly is regarded. Currently, people saving for retirement consider themselves to be saving for 'their' retirement. This means they put money aside for themselves and possibly their partner to cover costs when they stop working. This paradigm could be shifted from saving for 'their' retirement to family units planning for the future. This would involve family members considering how they could look after elderly members of their family in the future.¹³⁸ One point to consider could be the architecture of their family home. For example, families could consider the possibility of having an elderly member live in their home, if that elderly member was no longer able to live alone. Alternatively, they may consider the possibility of adding a self-contained unit to their property that an elderly member could live in rather than shifting straight to institutional care. Or they may invite an elderly member of their family to shift to the same street or suburb so that they could check on him or her weekly. Considerations such as these could lead to families being more equipped to look after elderly members through having foresight into ways that they could more easily connect with and support these people. These options are of course not available to everyone (and will not be preferable or realistic for all elderly persons), but families could at least consider alternatives, to moving their elderly members straight to institutional care facilities. It may also be beholden on governments to consider how these facilities could be best integrated with wider social life.

A number of these ideas have been implemented successfully led by Professor Hans Becker, the chairman of the Humanitas Foundation in the Netherlands. This is a not-for-profit organisation that manages 17000 'Apartments For Life' that were implemented in the mid 1990's. These apartments have been created for elderly members of society with a focus on retaining their own independence and staying

¹³⁸ In a recent symposium on healthcare for the elderly this issue has been raised. The following two articles were particularly relevant: R. Fan, X. Chen, and Y. Cao, "Family-oriented Health Savings Accounts: Facing the Challenges of Health Care Allocation," *Journal of Medicine and Philosophy* 37, no. 6 (2012). Also: T. Engelhardt, "Fair Equality of Opportunity Critically Reexamined: The Family and the Sustainability of Health Care Systems," *Journal of Medicine and Philosophy* 37, no. 6 (2012).

integrated within the community hence improving their quality of life. This challenges the often held assumption that people need to move into rest home care at the end of their life. The underlying philosophy as stated by Professor Becker is to allow ‘people to live a happy full life right to the end’, and to avoid ‘the island of misery that is created by institutional care’.¹³⁹

As this quote from Becker indicates the reasons for families taking greater responsibility for the care of their elderly members are not simply economic. If older persons are kept involved and connected to family life then this will facilitate many other benefits and may ultimately change the way we think about the ‘normal opportunity’ over a lifespan. I will explain this in the following sections.

6.3 Justice and opportunity

Plato said that justice is the best or ultimate good for a person.¹⁴⁰ To make sense of this claim one must be able to see one’s own good as bound up with the ‘good’ of society. One must recognize (as Plato did) that in order to live a good life one needs the support of others. This view of society is a step beyond the ‘liberal’ individualism typically associated with the Rawlsian perspective, and requires a commitment of shared responsibility for issues such as resource scarcity in order to create a positive outcome for society. It requires us all to consider how the challenges of the ageing population may be met together, and to adjust accordingly our perspective of the ‘normal range of opportunity’ that should be made available (in line with the Prudential Lifespan Account). Under the individualistic liberal model, one might think of the opportunities and possibilities that should be made available only in terms of the purposes that we hoped to fulfill in our ‘productive years’, i.e. before we reached retirement and ‘the ideal of old age’. However, a different perspective emerges if we think of the elderly as having an active role in their families and communities. In other words, if we think purely in terms of individualistic concerns, then life beyond retirement can seem devoid of opportunity. However, opportunities of a different kind arise through having a connection to others. These opportunities can remain available in retirement and throughout ‘old age’.

¹³⁹ Humanitas Foundation, "A summary of the Humanitas philosophy," <http://www.humanitas.nu>.

¹⁴⁰ J Weinstein, "Justice Brings Happiness in Plato's Republic," in *Just the Arguments: 100 of the Most Important Arguments in Western Philosophy*, ed. M. Bruce and S. Barone (2011).

The shift from an individualistic to a relational view aligns with Callahan's idea that we need to think collectively, and together acknowledge that we are each going to become frail and die. All of us experience at some point in our lives the vulnerability this will entail. Having acknowledged this fact, the fit and young should build a society where the elderly are valued and supported, so that when they are elderly they too will be valued and supported. This could turn the problem of resource scarcity and caring for the elderly on its head. If you value someone you want them to be a part of your life and to care for them. Hence planning for the future of the 'family unit' would not be regarded as a burden but rather as a necessary 'good'.

If the elderly are valued they will feel better about themselves and it is likely they will find ways to participate and contribute as best they can. We would still have to support those elderly members of society who were struggling, however allowing elderly members of society to contribute as much as possible could decrease the resource drain on society. This could also involve a reconsideration of our understanding of care. In a recent public lecture Baroness Finlay maintained that care of the elderly could be managed better through the involvement of non-professional carers.¹⁴¹ Many retired persons are fit and healthy and have energy to contribute to other people and the community. This energy is not currently being harnessed, partly it seems because society is set up in such a way that it is difficult for older citizens to contribute, and also because there is an expectation that all 'caring' should be done by trained professionals. However, if our fit and healthy retired members of society could be given the opportunity to care for those elderly persons who are not as fit and healthy this could help reduce the costs of care whilst providing those individuals with the 'opportunities' to contribute that justice requires.

6.4 The decline of community

The current lack of social responsibility for the 'ageing population problem' may be linked to a general decline in community, which has occurred over the past two centuries. People have become more isolated, and hence more individualistically

¹⁴¹ Baroness Finlay, *Risk Assessing Euthanasia*, (Public Lecture, sponsored by the Division of Health Sciences, University of Otago: 2012).

focused. This has contributed to the perception that the ‘government’ must take care of the welfare of society.

As a part of this decline in community there has been a measurable decline in social participation and connectedness. Several surveys in 1999 showed that 67% of Americans perceived social and moral values to be higher when they were growing up as compared to now and that American society had become more focused on the individual rather than the community. In addition to this, more than 80% of those interviewed felt that more emphasis should be placed on community even if this resulted in increased demands being placed on individual members of society.¹⁴² These studies were undertaken in both the US and the UK. At the risk of overgeneralization, I suggest that similar trends would be found in a country such as New Zealand, which is similar to the US and the UK in many relevant respects. With this in mind, I will discuss the effect that a decline in community has on the health of a population.

In recent decades public health researchers have established beyond reasonable doubt that social connectedness is one of the most powerful determinants of our wellbeing. Hence a decline in community has a negative impact on health. Correlated with a decline in community have been increases in depression and suicide along with decreasing self-reports of physical wellbeing. Conversely, the greater our integration in our community, the less likely we are to experience colds, heart attacks, strokes, cancer, depression and premature deaths of all sorts.¹⁴³ This is due, in part, to the ‘safety net’ associated with having people close, as people will notice if anything goes wrong. Additionally, social networks increase healthy norms¹⁴⁴ and tight-knit social groups are more likely to rally together politically to ensure adequate provision of

¹⁴² Another study supporting this showed that of baby boomers interviewed in the late 1980’s, 53% felt that their parents’ generation was better off in relation to ‘being a concerned citizen, involved with others’. Only 21% felt that their own generation was better off. In: D Putnam, *Bowling Alone: The Collapse and Revival of American Community* (New York: Simon and Schuster Paperbacks, 2000).

¹⁴³ Involvement in the community involves social connectedness such as; family ties, friendship networks, participation in social events and affiliation with religious associations. James House concluded that the beneficial contributions to health seen through social integration are similar in strength to the harmful effects of health risk factors such as smoking, obesity, increased blood pressure and sedentary lifestyle. In: *ibid.* pp. 326-27

¹⁴⁴ Individuals who are isolated have an increased likelihood of smoking, drinking and overeating.

healthcare. Finally, being part of a social group has been shown to stimulate the immune system of individuals and help mitigate stress levels.¹⁴⁵

‘Social capital theory’¹⁴⁶ is based on the idea that social networks have value and influence the productivity of individuals and groups. Research shows that social capital is important for the wellbeing of both individuals and societies, and can be considered both a ‘public good’ and a ‘private good’. Thus, a well-connected person in a poorly connected society is not as productive as a well-connected individual in a well-connected society, and that ‘even a poorly connected individual may derive some of the spillover benefits from living in a well-connected community.’¹⁴⁷ This implies that a well-connected society will result in an overall society that is better off and that is made up of persons who will have a greater sense of personal wellbeing and greater levels of personal productivity. This is in line with principles of justice, as it will provide an outcome that is better for everyone. It will also allow the opportunities available in the community to increase for everyone, including the elderly.

Social capital and connection has also been shown to sustain strong mutual obligations and norms of reciprocity. Reciprocity can be both specific (when you do something for another person and know they will return the favour with a specific action) and also generalized (where the exact exchange of goods or services is not kept track of, but over time it is expected that they will balance out). Societies that work on generalized reciprocity have been shown to be more efficient than distrustful societies (‘trustworthiness lubricates social life’).¹⁴⁸ Therefore, if we can create reciprocity in a well-connected society it is likely that the positive benefits will be magnified. Hence, we need to consider how we can structure our communities to

¹⁴⁵ Social isolation has been identified to be a ‘chronically stressful condition in which the organism respond[s] by ageing faster’. Studies have shown that ‘people who are socially disconnected are between two and five times more likely to die from all causes, compared with matched individuals who have close ties with family, friends and the community.’ In: Putnam, *Bowling Alone: The Collapse and Revival of American Community*; *ibid.*

¹⁴⁶ Social capital refers to connections that exist among individuals: ‘social networks and the norms of reciprocity and trustworthiness that arise from them’. In: *ibid.* p. 19

¹⁴⁷ *Ibid.* p. 20

¹⁴⁸ *Ibid.* p. 21

maximize what have been identified as the positive benefits of a close-knit community: mutual support, trust, cooperation and institutional effectiveness.

In summary, justice points us towards creating a society where all citizens act to meet the issues facing that society. One reason that we do not currently have this attitude is because over the past two centuries citizens have adopted a more individual focus in place of a community focus. However, a well-connected community has been shown to have positive health effects for citizens, greater productivity and to support the creation of reciprocal relationships between members of that society. These benefits would equip us to face the challenges of the ageing population. I will now briefly consider how this community decline might be addressed.

6.5 Addressing the decline in community

As a case study, one may consider what has been described as the ‘Gilded Age’ (1870-1900) and the ‘Progressive Era’ (1900-1915) in America. During these times American society faced problems that parallel those we face today: social, economic and technological changes that left a large amount of social capital obsolete. Nowadays these changes take the form of television, the internet, generational value changes, suburban spreading and families with both parents working full time. During the Gilded Age the breakdown of social capital occurred through the industrial revolution resulting in urbanization and shifts of people from rural to urban areas. Consequently the typical ‘symptoms’ of a deficit in social capital resulted: increased crime, substandard education, a widening gap between the rich and poor, low standards of health, and political corruption. However, during the next thirty years America reversed this trend through ‘a quickening sense of crisis coupled with inspired grassroots and national leadership’.¹⁴⁹ Following this a period of social ingenuity and political transformation ensued. It was during this time that the majority of today’s dominant community institutions in America were developed. If America could come back from such huge social capital destruction in the ‘Gilded Age’ and ‘Progressive Era’, so too can New Zealand today. Putnam has referred to

¹⁴⁹ Ibid. p. 369

this as follows: ‘as we enter a new century, it is now past time to begin to reweave the fabric of our communities’.¹⁵⁰

6.6 Conclusion

The Prudential Lifespan Account shows us that there is a duty to protect the normal opportunity range for all generations. This supports a basic principle of age-based allocation, in that it shows that a younger person will have a greater claim to healthcare resources than a person who has achieved the expected lifespan. It is unjust for a generation to consume resources at the expense of those that follow. However, the Prudential Lifespan Account does not justify age-based allocation for all kinds of treatment. Furthermore, a basic principle of age-based allocation would not fully address the challenges we are currently facing as a result of the projected population changes.

Society must find other ways of upholding intergenerational justice. In this chapter I have outlined some possibilities: collective saving schemes, ‘family unit’ planning for the future and the development of strong community connections. It seems that fundamentally we require an attitude where all members of society take responsibility for issues facing that society. This would require a shared understanding of principles of justice, which involve recognising the importance of giving the elderly the opportunity to contribute, be active members of the community and enjoy the benefits of social connectedness that come through community spirit. In my view, this is the platform on which we should build a response to the challenges brought about by our ‘ageing population’.

Given the ageing population, The Beatles’ song ‘When I’m Sixty-Four’ may have been renamed ‘When I’m Eighty-Four’. In the light of my conclusion our answer will be ‘we will still need you and we will still feed you when you are eight-four’.

¹⁵⁰ Ibid. p. 403

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