Rationing

Are age and “contribution to disease” morally relevant factors?

Mammograms

- Distinguish risk-benefit from cost-benefit
- Factual: yearly mammograms for women in their 40’s will save 1 in 1900. (For women in their 50’s, about 1 in 1300).
- Normative: 1 in how many would justify the yearly mammograms?
- Yearly over 10 years is 19,000. Apparently 1,000 will be false positives.
  - 18,000 negative mammograms: relief and peace of mind
  - About positive mammograms: 1 will save a life, but how much negative from the others? (Anxiety, radiation danger, any lives lost from that?)

Some Facts about age

- 1980, 1986: those over 65 consumed 29%, 31% (respectively) of health care expenditures
- Prediction: by 2040 elderly 21% of population and 45% of health care money.

The Harm This Does

- Economic burden on young
- Too much emphasis on health care compared to other needs

Three Concerns

- Intergenerational equity: Health care going to elderly at expense of children (6x as much spend on elderly compared to under 18).
- Elderly dying consume 1% of gross national product.
- Expenditure for technology (research, etc.) helping mainly the elderly

Challenges to Callahan

- What helps elderly helps all (e.g., relieves burden of care from children).
- Elderly get more because they need more, so it’s not “disproportionate.”
Age-based rationing

**Raises Larger Issues for Medicine**
- These issues not easily dealt with in a democracy concerned with short-term
- **What is the appropriate role of medicine?**
- Callahan (thesis): the future goal of medicine in the care of the aged should be improving quality of life, not extending life.

**Raises Larger Issues for Society**
- **New understanding of aging needed:** one can have a meaningful old age limited in time.
- Our culture needs a more supportive attitude toward aging and death.
- Culture should recognize that the primary orientation of the elderly "should be to the young and the generations to come, not to their own age group."

**Opposing View of Our Culture**
- "Modern Maturity" and "Prime Time: Older years a time for education, travel, leisure.
- An extended middle age without work responsibilities

**Callahan: a “Natural Life Span”**
- We should accept something like Biblical idea of a natural life span, beyond which we don’t fight to extend.
- Medicine should work to prevent premature death and mainly relieve suffering afterward.

**Applied to Health Care Spending**
- Communal programs (government) should help people live a natural life span.
- Research priorities should reflect this.
- Health care should not be based only on need without regard to age.

**Childress—A Different View**
- Quotes Robert Browning:
  "Grow old along with me
  The best is yet to be
  The last of life for which the first was made."
Age-based rationing

**British Experience**
- No official barrier to dialysis, but
- Many centers denied care to patients (e.g., one 68 years old) purely based on age or (e.g., a 60-year-old) with age as one reason.
- This is changing, but NICE does deny cancer drugs to some patients.

**Is Age Discrimination Like Racial or Sexual Discrimination?**
- We don’t have control over it
- However, we all go through different stages

**Consider Three Possible Approaches**
- Rawlsian
- Utilitarian
  - Cost-benefit analysis
  - Cost-effectiveness analysis
  - Expressive or symbolic significance

**Rawlsian Approach**
- What policy would we accept in original position?
- Using “maximin” idea (we’d want to avoid the worst), we might want to be guaranteed a certain age
- Might be rational to adopt a health care strategy to increase chance of reaching a normal life span.
- Or would we simply choose to spend more on health care (denying ourselves other things) to have a better chance for the Golden Old Age?

**Should We Use Cost-Benefit Approach?**
- “Biggest bang for the buck” in all areas.
  - Compare money spent on different forms of health care both with other forms and non-health care expenditures.
- Needs to consider $ value of human life
  - Expected future earnings
  - [More usual now] Willing to pay to reduce risks.
  - Problems with surveys.
  - Either of these might give less weight to elderly

**Cost-Effectiveness Analysis**
- Need not consider $ value of human life but compare different health policies for how much “good” they produce.
- “Good” often translated into QALYs: “quality adjusted life years.”
  - Need to determine what percentage of a “quality” life a given disability represents.
  - Example: treat a blind person and a sighted person. If being blind represents a reduction of 20% in quality, then prolonging life gets 20% fewer QALY points.
  - How do we get these numbers? Can surveys determine this?
  - How many additional years would you need to live for you to choose being blind (deaf, on dialysis, with arthritic pain, etc.) or how many fewer years would you choose if you could be free of a problem?
Age-based rationing

“Symbolic” or “Expressive” Significance
- Separate from justice, which is about what we owe people as a matter of right.
- Pres. Commission: “a society’s commitment to health care reflects some of its most basic attitudes about what it means to be a member of the human community.”
- Also, when Pres. Commission represents CBA, it included value of "communal solidarity" as benefit.
- Maybe this is just a broadened form of utilitarianism. Will come up in other issues; e.g., is surrogate motherhood “selling a baby” or “renting a womb”
- Related to commodification. If we treat body a certain way (e.g., neomorts), that has a “negative symbolic significance.”
- Might withholding available medical care from the elderly be immoral (even if cost-effective) because of its “negative symbolic significance”? 

Effects of the “War” Metaphor
- Our “battle” against disease may increase health care budget too much. Fighting an evil.
- Gives greater priority to critical care and fighting “killer diseases” over prevention and chronic care.
- Emphasis on technological intervention. (Typically American? Tertiary care.)
- Leads to overtreatment, especially of terminally ill. Death is the evil to fight and overcome with “heroic” efforts.
- Maybe we need metaphor of nursing.
  - Interesting to consider different “ethic” of physicians and nurses.

Responsibility for disease
Essays on this topic (for 11/23):
- Cappelen and Norheim, “Responsibility in Health Care: a Liberal Egalitarian Approach”

Responsibility for One’s Disease
- Should policy take into account the extent to which a disease is partly the result of a patient’s past behavior?
- Utilitarian reason: to provide incentives that will improve health behavior
- Nonconsequentialist (“backward-looking”): hold people responsible for their past choices
  - Note parallel with utilitarian and retributive justifications for punishment
- Focus of article will be “backward-looking”: treating people differently even if it does NOT affect future behavior

Arguments against responsibility
- Humanitarian: “are we going to let just suffer and die?”
- "Liberal": it would also deprive people of basic political rights
- Fairness: it holds people responsible for consequences over which people have no control
- Practical: doctors would have to be intrusive to know about past behavior

Better “liberal egalitarian” way
- Hold people responsible for their choices, not the consequences of their choices
- Example: 2 people choose to smoke. One is unlucky enough to get cancer, the other is genetically luckier
- Good way to apply this: tax smoking but don’t treat people differently when they get a behaviorally related disease.
Age-based rationing

Still some issues
- Hard to know which choices are under one’s control
- Maybe unhealthy behavior is not freely chosen but the result of genetics and environment (e.g., physiologically based depression causing alcoholism)
- Which behaviors do we tax? Failure to exercise? Eating fatty foods?

Alcoholism and liver disease
- Thesis: there is no good justification (moral or medical) to deny liver transplants to alcoholics

“Moral argument” fails
- The “moral argument” for denial fails: the health system doesn’t deny transplants other kinds of immorality, like being an abuse parent
- Also hard to know how responsible people are in becoming alcoholic

“Medical argument” fails
- Not even clear that alcoholics have less success after transplant
- Even if so, it should be regarded no differently from other medical factors likely to lessen chance of success
- We should not mix in our moral disapproval of alcoholism