Justice, Health Care, and the Elderly

Am I my Parents’ Keeper. by Norman Daniels; Setting Limits. by Daniel Callahan

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A dominant theme in both public and policy-making discussions of health care in recent years has been the need to control relentlessly escalating health care costs. One widely perceived and important cause of this problem has been the “graying” of America—recent and anticipated increases in life expectancy and in the proportion of the population over age 65, and especially the even more rapid increase in the “old old” population. The increased numbers of elderly in turn make disproportionately large use of health care. In response to any proposals to limit the availability to the elderly of resources generally, and health care resources in particular, their advocates have added the charge of “ageism” to the more familiar charges of racism and sexism. From the other side and in the face of the daunting political power of the elderly wielded by politicians such as Claude Pepper and lobbying groups such as the American Association of Retired Persons, the argument is increasingly heard that making Social Security or Medicare programs relatively immune from the budget cuts suffered by other domestic programs is creating intergenerational injustice—that the welfare of children and working-age Americans is being wrongly sacrificed for the benefit of the elderly. The intensifying policy debate over health care and other social support programs serving the elderly is forcing a rethinking of questions of intergenerational justice and the claims of the elderly on social resources.

Norman Daniels and Daniel Callahan have written books that address...
these issues. While the arguments of both, and especially of Daniels, extend beyond health care, their central focus is on what I will here call the age-group problem—what ethical claims do the elderly, as compared with other age groups, have on social resources for the provision of health care? Both conclude that some direct appeals to age in the determination of these claims can be ethically unobjectionable, though the nature of their arguments as well as the conclusions they reach are in many important respects very different. Daniels's argument is squarely within the tradition of political liberalism, while Callahan calls on a communitarian political philosophy. Despite these differences, I will argue that central parts of what is most interesting and plausible in each's view are compatible and that not losing sight of them will yield a richer and deeper public debate about health care for the elderly. Precisely because of these differences in broader political philosophy, my disagreement with Callahan runs considerably deeper than my disagreement with Daniels, and I shall criticize some of the features of Callahan's position that have generated the most controversy. I believe it would be unfortunate, however, if public attention and policy discussion focused only on some of his more controversial and problematic ethical claims and policy proposals, thereby losing sight of what I consider an important contribution to this debate. In Daniels's case, I have less to disagree with, but will show why the nature of his overall theory of justice in health care leaves him largely silent on the important question Callahan addresses.

One possible ground of obligations to meet the needs of the elderly is filial obligations, but both Daniels and Callahan reject this route. Whatever the truth about how much such care was provided in the past either in our own or in other societies, tradition alone cannot guide us now because of the great increase in the needs of the elderly—a greater proportion of the population lives into old age, those who do so live a longer period of old age, and, because medical care can and often does sustain their lives during long periods of disability and dependence, their needs for care while elderly are commonly much greater than in the past. Yet it is precisely in cases where the needs of the elderly are so great as to overwhelm the capacities of their grown children to pursue their own lives while meeting those needs that an account of how much care is owed the elderly and by whom is most needed. Both Daniels (D, pp. 28–34) and Callahan (C, pp. 84–106) argue that no general moral argument succeeds in showing that children are obligated to provide the care their parents need. Moreover, there is no consensus among actual families on
the care and aid that children owe their elderly parents which might instead guide public policy.

It is worth adding that even if there were a single sound argument establishing what aid and care children owe their parents, this could not by itself adequately guide public policy concerning care for the elderly, for the simple reason that it would not tell us what care is owed the elderly who are childless, or whose children are no longer living or are otherwise unable to provide the care. Nor could such an argument ground a social policy supporting the childless elderly in the manner and to the degree that elderly parents are owed support by their adult children, since it would presumably be the actual care given children that would obligate the children in turn to care for their elderly parents. The elderly who have never had children have never provided any care on which a reciprocal obligation to care for them could be based.

How then are the claims of the elderly to socially supported health care to be determined? I believe the conventional view in medicine is that there is no special problem of what health care justice requires be made available to the elderly as opposed to other groups. There is only the general problem of determining the adequate level of health care that justice requires be available to all citizens. Both physicians and health policy analysts commonly urge that only patient need should be relevant to allocating health care; in conditions of scarcity we must simply meet the most important or urgent health care needs. In this view, the health care needs of the elderly, like those of all others, should be considered solely in terms of their importance or urgency and not discounted simply because they are the needs of the elderly. Of course, both the health care needs and the expected benefits of treatment of many elderly may vary in systematic ways from those of younger patients, but it is these differences, not differences in age, that are relevant for determining their claims to social resources for treatment. In the conventional view, differential treatment based on age itself is unjust ageism. Both Daniels and Callahan reject this conventional view, though for very different reasons.

In an earlier book Daniels developed a general theory of just health care within a broader liberal political philosophy of a generally Rawlsian form.1 Now he extends that general theory to the problem of what health care is owed the elderly as opposed to other age groups. His account exploits the central fact that we age and so in the course of our lives can

expect to pass through each of the stages or age periods of a normal lifespan. As a result, the much-discussed competition for resources between young and old is misleading in suggesting a conflict between different groups of persons. Instead, it is possible to frame the question of distribution of resources between different age groups as a problem of prudential reasoning for a single individual about how to distribute resources over the different stages of his or her own life. Daniels calls this the “prudential lifespan account.” Institutions such as Social Security and health care insurance plans take more resources from workers in their middle, productive years than are returned to them then in benefits, but in turn provide more in benefits during retirement years than are then taken in taxes or premiums. Instead of thinking of these as interpersonal group transfers, we can regard them as intrapersonal savings plans for persons as they pass through these institutions over the course of a lifetime (D, pp. 42–47). At any particular stage of life, all persons will be treated the same, though different birth cohorts will reach a particular stage of life at different times.

The prudential lifespan treatment of the age-group problem presupposes that we have both a general theory of distributive justice and a theory of just health care, which together determine what is a fair lifetime share of health care for members of a particular society at a particular time. Specifically, Daniels assumes, first, that the general theory of justice will include some principle of fair equality of opportunity requiring that “opportunity be equal for persons with similar skills and talents” (D, p. 70). Second, he assumes that the importance of health care for justice is determined by its effects on a person’s opportunity, and so a fair share of health care is determined by what is necessary to maintain fair equality of opportunity over a lifetime. Prudential planning for health care needs will then require an individual to choose a particular set of institutions that will distribute health care to her as she lives her life and passes through these institutions. Prudence requires neutrality towards all the stages of one’s life, and not biasing the choice of institutions to favor one’s present stage. For this, a Rawlsian veil of ignorance regarding one’s present age or life stage would seem a natural device. We might think of these prudential planners as knowing their aims and values or plans of life at all stages of their lives, while the veil of ignorance only deprives them of knowing what stage is “now.” However, because our plans of life change over the course of our lives, very often in major and
largely unpredictable ways, planning based on knowledge of what our life plans will be over the course of our lives is not possible.

Instead, Daniels argues that the neutrality that prudence requires towards our different life stages can be obtained by seeking to provide ourselves with a roughly equal opportunity at each life stage to revise and carry out our plans of life then, whatever they turn out to be. Prudential planners can achieve this by securing for themselves a bundle of Rawlsian primary goods that will provide them with a fair share of the normal opportunity range for their society at each stage of life. In then planning for health care at different life stages, it will be rational for them to take account of the general prevalence of different diseases at different stages of life, of the effects of those diseases on the range of normal opportunity at particular stages of life, and of the possibilities and costs of treating those diseases. For example, Daniels shows how the prudential planners’ focus on opportunity supports a substantial strengthening and expansion of long-term care services for the elderly (D, chap. 7). Prudential planners can be expected to provide for significantly different kinds and amounts of health care at different stages of life, since the nature and prevalence of disease, the effects of diseases on normal opportunity, and the benefits and costs of treating disease vary substantially at different life stages. Because their lifetime fair share of health care will not provide all possible beneficial care for all their health care needs without regard to cost, all of these age-related differences will affect how they allocate between different life stages in these conditions of moderate scarcity.

Since prudential planners allocate their lifetime fair shares of health care relative to needs at different life stages, it may not be clear how Daniels’s prudential lifespan approach differs from the conventional appeal to needs. The difference can be brought out by considering what Daniels calls “pure age rationing”—making differential treatment available to persons of different ages not because they have different health care needs, but simply and only because they are members of different age groups. The most important and controversial case is life-sustaining treatment.

Daniels argues that his prudential planners could face choices under

2. Daniels defines the general notion of “the normal opportunity range for a given society” as “the array of life plans reasonable persons in it are likely to construct for themselves” (D, p. 69). The prudential planners disaggregate this notion and employ an age-relative opportunity range for different life stages.
conditions of substantial scarcity in which an increased access to life-extending resources in one's later years requires a reduced access to them in earlier years; greater use of these resources late in life will require increased saving in one's productive years. For example, increased access to acute care interventions employing expensive, high-technology care, such as treatment in an intensive care unit, could require cuts in prenatal care leading to an increase in infant mortality rates or cuts in immunization programs for potentially fatal infectious diseases that strike early in life. His example compares scheme A (for age rationing), in which no one over age 75 is offered any of several high-cost life-extending technologies (such as dialysis, transplant surgery, or extensive bypass surgery), and scheme L, in which allocation is strictly by medical need, so that only one of the high-cost technologies can be developed and made available to all who need it (D, pp. 87–88). To simplify, assume that A offers a 1.0 probability of living to age 75 and then dying immediately, while L offers a 0.5 probability of living to age 50 and a 0.5 probability of reaching age 100. Life expectancy is identical in A and L, with the difference that L trades some expected life years before one has reached the normal lifespan of 75 for the possibility of life years beyond the normal lifespan. Scheme A differs from the conventional appeal to health care needs because under A a person below age 75 will receive an expensive treatment like bypass surgery, while someone over 75 will not get it, though both may have the same coronary disease and medical need for and expected life extension from the surgery.

Daniels offers two reasons why prudent planners would prefer A—the age-rationing scheme (D, pp. 89–91). First, they would know that the incidence of disease and disability is greater between ages 75 and 100 than between 50 and 75, and so the quality-adjusted expected life years are commonly greater under A than under L. Second, they would know

3. It should be added that Daniels appears to believe that scarcity now is not severe enough to force such choices. Whether this is correct will depend on complex questions concerning trade-offs both between different health care resource uses and between health care and other resource uses. In the context of ideal theory, it may be defensible to assume no restrictions on possible resource trade-offs available to planners. However, for real-world policy planners the level of scarcity assumed will depend on an assessment of feasible policy alternatives given political and other constraints on possible reallocations. Here it will not do to resist claims of scarcity of health care resources on the grounds, for example, that “Star Wars” weapons funds would be better spent on health care, unless such a reallocation is feasible for policymakers.
that while in some lives and life plans the “golden years” beyond age 75 may even be among a person’s best years, in most life plans important plans and projects will be largely completed by age 75, making the 50-to-75 period more important than the 75-to-100 period. This shows that prudent planners could prefer A—the age-rationing scheme—and that age rationing is not per se unjust in comparison with allocation according to medical need. The one paragraph Daniels devotes to the second reason, however, quite underplays its importance (D, pp. 90–91).

Callahan’s notion of a “tolerable death” is helpful in bringing out that importance. A tolerable death is a “death at that stage in a lifespan when (a) one’s life possibilities have on the whole been accomplished; (b) one’s moral obligations to those for whom one has responsibility have been discharged; and (c) one’s death will not seem to others an offense to sensibility, or tempt others to despair or rage at the finitude of human existence” (C, p. 66), and, he adds, (d) the death must not be “marked by unbearable and degrading pain” (C, p. 72). Such a death “may be understood as a sad, but nonetheless relatively acceptable event” (C, p. 66). This is, I believe, an important notion which seeks to distinguish, at least with conditions (a)–(c), deaths that we accept as simply a normal and inevitable part of the human condition—the mortality we all share—from those that we tend to characterize as a tragic or unfair cutting short of a life in process. As Callahan notes, this notion of a tolerable death appeals to the idea of a life in a narrative or biographical, not simply a biological, sense (C, p. 66). A tolerable death occurs at a point at which what a person can largely expect from and within a human life is not denied by the death, though it is still a sad event and a loss for the person whose death it is and for the others who cared about the person. Our own death is the central and overriding inevitability in our lives (more inevitable even than taxes—a few do succeed in evading them). However consciously and explicitly, our lives, and the plans we make for them, are fundamentally shaped by what we can expect in the way of a normal lifespan. While death can be hard and may be resisted at any age, it is a death before one has had the opportunity to complete a normal lifespan that will often seem an unexpected and bitter deprivation.

Callahan’s notion of a tolerable death underscores the importance of the second reason Daniels offers for why an age-rationing scheme need not be unjust—we plan our lives and what will fill them based on expectations of what is a roughly normal lifespan in our society. Because we
commonly try to give our lives continuity and coherence, as biographical lives lived by us from the “inside,” the loss of life years needed to reach a normal lifespan and “complete that biography” is commonly a signifi-
cantly greater loss than the loss of a comparable number of life years needed to live beyond the normal lifespan. Thus, if we simply look to the good we can do for persons whose lives are extended by the provision of life-sustaining medical care or by other health policies, we can often do substantially more good by preventing deaths before instead of after the normal lifespan has been reached.

It may be objected that this claim is class-biased, and true only for persons whose work is satisfying and rewarding, but not for the many whose work is largely drudgery and who may look forward to relief from it in retirement. Two points largely, though not completely, undercut the force of this objection. First, a normal lifespan of at least 75 to 80 years already includes a significant number of these retirement “golden years,” including those most likely to be free of disability. Second, even for many whose work may be largely drudgery, other central and satisfying projects of their lives, such as raising their children, are completed within the normal lifespan.

The distinction between a premature and a tolerable death suggests that an argument based on a moral principle of fair equality of opportunity could directly support assuring the life years necessary to live out a normal life, at least where doing so is technologically and socially possible. Such an argument would be independent of whether the prudential lifespan account is accepted for the age-group problem. This opportu-
nity-based moral claim would not be absolute, in the sense of being un-
limited no matter what the cost of meeting it, just as Daniels’s broader account of a person’s just claims to health care grounded in fair equality of opportunity is not unlimited no matter what the cost of meeting it. My suggestion is that the notion of fair equality of opportunity might be ex-
tended not just to apply to health care generally, as Daniels did in Just Health Care, but also to morally differentiate the claims to life-extending health care up to, as opposed to beyond, the normal lifespan. Daniels rejects this line of reasoning (D, pp. 92–93). But it is, I believe, a plaus-
sible use of the distinction between a premature and a tolerable death, which should fit within broader theories of distributive justice that in-
clude a principle of fair equality of opportunity. It should not conflict in major ways with the substantive implications of Daniels’s prudential
lifespan account, but instead has some promise of providing an independent moral argument that would largely reinforce at least some of the broad implications of his account. Both arguments establish that under some conditions of scarcity what I will call *weak age rationing*—giving greater weight to the claims on social resources for life-sustaining care up to, as opposed to beyond, the normal lifespan—need not always be unjust.

In this respect, more use can be made than Daniels does of a principle of fair equality of opportunity for determining a just allocation of resources to life-extending health care. In a different respect, however, I believe Daniels’s theory places too much moral weight on opportunity in a way that his own prudential lifespan account highlights. His treatment of the age-group problem here inherits a difficulty in his more general theory of just health care. Some critics of that theory have argued that it is a mistake to hold that the relevance of health care to justice lies only in its effect on opportunity.4 Instead, health care is important also for its effects in relieving or preventing pain and suffering and in improving the quality of life in respects independent of opportunity. Prudential planners would allocate some of their fair share of health care resources to achieve these non-opportunity-based ends. But if such ends have been ignored in the determination of individuals’ fair lifetime shares of health care resources, then there is an incoherence between Daniels’s general theory of just health care and his prudential lifespan treatment of the age-group problem. Prudential planners will want to allocate their fair lifetime shares of health care resources in part to serve ends other than opportunity for which no provision was made in the opportunity-based determination of those shares. This difficulty, however, lies in Daniels’s general account of just health care, and with appropriate revision of that account the prudential lifespan treatment of the age-group problem is, in my view, essentially sound.

While Daniels’s treatment of the age-group problem is squarely within the tradition of broadly individualist and pluralist liberalism, as represented within political philosophy most prominently by Rawls, Callahan rejects central features of that tradition. Daniels’s theory of just age-

group distribution, like Rawls’s broader theory of justice, rejects appeal to any one substantive account of the good life, appealing instead to the liberal view of justice as establishing the terms of social cooperation within which individuals are left free to choose and pursue their own inevitably differing plans of life. Thus, in Daniels’s theory persons will seek to secure a bundle of primary goods, including health care, that will provide them with roughly equal opportunity at all stages of their lives to pursue their conception of the good life, whatever it happens to be and as it changes over their lives. Against this aspect of traditional liberalism, Callahan holds that social policy towards the elderly should be based on a communal consensus on the proper meaning and ends of aging and old age.

Callahan is especially concerned to reject what he calls the modernized view of old age, which sees it as providing simply more of the same kind of life, emphasizing the pursuit of private aims, as when one was young (C, pp. 26–31). The modernized view seeks essentially to banish old age and to avoid death as long as possible, if not to deny death’s existence altogether. It denies the limits that aging and death place on our lives, to which Callahan wants to give due place. The modernized view of old age, he argues, will inevitably fail because however much the wonders of modern medicine may delay the onset of decline in our powers and our ultimate death, it cannot succeed in banishing them. We need a different view of the meaning and ends of old age that acknowledges it as the period when our lives, as seen both in the biological sense and from the inside in a biographical sense, are drawing to a close and reaching a completion.

According to Callahan, the primary purpose of old age and of the old should be the service of the young, of the generations that will follow (C, p. 43). By virtue of being near the end of their own lives, lives which can be seen as integrated and coherent wholes, the elderly are uniquely situated to integrate past with present, to understand the way past, present, and future interact, to show what it means to live in the present and not always for the future, and to help the young come to understand what it is to live a meaningful life that does not need continually to deny that all such lives must inevitably come to an end (C, pp. 44–48). For the elderly to play this role, Callahan repeatedly emphasizes, a fundamental and deep change will be required in our society’s common view of the place of aging in a complete life, a change that if it comes at all will take at
least a generation of public debate to bring about (C, pp. 199–200). Changes will be required both in the way the young view aging and the old and in how the elderly themselves view their current stage of life. Callahan believes that such a transformation in the way aging and old age are viewed would benefit the elderly in giving them a richer, more satisfying view of the meaning and ends of aging and of a complete life.

What would follow from this transformed view of aging and old age for health care policy, specifically as it concerns allocation of resources for the elderly? In the broadest terms, Callahan argues that the suitable goal for medicine would be the achievement by all of a natural lifespan and, beyond that, only the relief of suffering. Government would have no obligation to help people extend their lives medically beyond the natural lifespan, no responsibility to provide “any medical intervention, technology, procedure, or medication whose ordinary effect is to forestall the moment of death, whether or not the treatment affects the underlying life-threatening disease or biological process” (C, pp. 137–38). At the same time Callahan argues, like Daniels, for substantial expansion in the provision of long-term care and support services for the elderly. Thus, it is a mistake to view this change in perspective as merely a thin guise for cutting spending on the elderly—while it would support cuts in some areas, it would require major new commitments of resources in other areas.

Callahan in fact displays considerable ambivalence about the relation of scarcity, and an increased awareness of scarcity, to his proposal. On the one hand, he notes the familiar data on the expanding numbers and proportion of the elderly in society, as well as their disproportionate and rapidly growing use of health care resources, and comments more than once that we cannot continue to pour resources into extending life and postponing death (C, pp. 21, 137; appendix). On the other hand, he also repeatedly notes that his motivation is not simply to reduce health care expenditures, but instead to provide a revised view of aging and old age that will be a benefit to and improve the lives of the elderly as much as the young (C, pp. 53, 116). Moreover, he explicitly adds that it would be unjust to restrict provision of care to the elderly merely in order to save

5. In this respect, it is worth noting that Callahan was defending the main features of his view before the current obsession with cost containment developed. See his “On Defining a ‘Natural Death,’” Hastings Center Report 7 (1977): 32–37.
money and in the absence of this change in view of aging and the elderly (C, p. 153).

Callahan suggests several implications of this revised view of aging and old age for how we set priorities in public policy towards the elderly. First, “no new [medical] technology should be developed or applied to the elderly that does not promise great and inexpensive improvement in the quality of their lives, no matter how promising for life extension” (C, p. 143). Second, the system of providing equitable security to the elderly against the loss of financial and other independence must be greatly strengthened (C, pp. 146–48). Third, priorities for research and care should be given to the causes of premature death, chronic diseases that burden the later years, and support services that reduce suffering and increase the quality of life, such as improved home care (C, pp. 148–53).

Much of this reorientation is well taken, but clearly most controversial in Callahan’s proposal is his support of strong age rationing—the elderly should have no entitlement to social resources for the provision of life-extending care once they have reached a normal lifespan, that is, the late 70s or early 80s. (Callahan explicitly does not support what can be called very strong age rationing, which would prohibit persons even from using their own resources to purchase such care. He explicitly allows for private markets in this care, but notes the moral and political difficulties facing such a two-class system.) Precisely how is this strong age rationing of life-extending treatment beyond the normal lifespan to be justified? I believe Callahan’s answer is related to his dissatisfaction with pluralistic liberalism. Against that liberalism, he insists that it is necessary to reach a social consensus on the meaning and ends of aging and old age, a consensus on a single view of their meaning and ends (C, p. 220). He insists on this because he believes that we require a social policy concerning health care for the elderly, and that such a policy’s legitimacy must lie in a social consensus it both rests on and expresses. If a “consensus” is understood along very strict lines as meaning that essentially all members of society share the view, and the consensus is informed and has been freely arrived at by those members, it would then not be necessary to impose the policy of not providing life-extending care to persons beyond the normal lifespan on anyone who does not accept that policy, even if weakness of will may lead some to seek to get such care when they come to need it. If all freely and knowingly accept the policy, then it is unnecessary or superfluous to provide any further argument.
that justice requires it. But is there any reason to expect such a strong consensus to come about in this country? I think the answer must clearly be no.

People now find meaning in their later years in many different ways and pursue a host of different ends in those years. Moreover, that seems inevitable in a large and diverse country that celebrates its pluralism and gives such high value to individual liberty. Since a strong consensus on the meaning and ends of aging and old age would likely require deep and pervasive social transformations, including deep restrictions on highly valued liberties and on individual self-determination in shaping one’s own conception of the good, we have good reason to resist steps for achieving such a consensus in the United States. But in the absence of such a consensus, we need a justification for the denial of all social entitlements to life-extending care beyond the normal lifespan for those who reject the consensus and want that care. Since Callahan’s only justification seems to suppose this missing consensus, does that mean his position must be systematically rejected? I think not.

Callahan’s book has forced into the foreground of the debate about health care and the elderly the extremely important questions that *individuals* must face about how they will find meaning in old age and what ends will guide that stage of their lives. Many will no doubt reject the answers that he offers to these questions. But many others will find his criticisms of the modernizing view important and the alternative ideal of aging and old age that he offers deeply attractive. That his answers to these questions will achieve no full consensus does not detract from the importance of the questions or the answers. In fact, I believe it is here that his book’s greatest strength and importance lies. Nevertheless, the absence of any strong social consensus along these lines undermines Callahan’s appeal to a communitarian basis for at least the restrictive aspects of his policy proposals regarding social entitlements to health care for the elderly, and specifically to life-extending care beyond the normal lifespan. In seeking a basis for public policy in a pluralistic society like ours that lacks, and will continue to lack, any strong social consensus on the proper meaning and ends of aging and old age, I believe we must turn to liberalism and an approach largely along the lines of Daniels’s prudential lifespan account. Specifically, it is to that approach that we must turn in thinking about just distributions of resources between different age groups. However, just because liberalism appeals
only to a thin theory of the good for persons and rejects any appeal to a single, thick account of the meaning and ends of life in general, or old age in particular, we will find it largely silent on these issues of most importance in Callahan’s book; Daniels’s book in particular says little on them.

It is then in the following respect that Daniels’s general theoretical framework—the prudential lifespan account—for just age-group distribution is compatible with Callahan’s proposals concerning the meaning and ends of old age. Those proposals offer what many persons living within an institutional framework whose age-group distributions meet the requirements of the prudential lifespan account would find an attractive and appealing view of the meaning and ends of old age for themselves and their own lives. For carrying out this view that they have freely adopted of their old age in the context of specific decisions about their medical treatment, should they later be unable to decide for themselves, such persons might employ advance directives such as living wills and durable powers of attorney for health care. Some of Callahan’s other policy recommendations and priorities might be revised so as to affect only those who have freely adopted his view of the meaning and ends of old age, though I shall not explore that possibility further here. But this is not to say that these restrictions on social entitlements to life-extending care should be imposed as a matter of public policy on persons who have not freely adopted this view of old age as their own. For determining just age-group distributions, Daniels’s prudential lifespan approach is the more reliable guide.

Before concluding, I want to say a bit more about the specific policy issue of life-extending care beyond the normal lifespan. This issue has understandably been the focus of a great deal of attention, though other proposals like improving long-term care and home care services for the elderly, on which, as I have noted, Daniels and Callahan agree, would probably have a greater overall impact on the well-being of the elderly. Can we use prudential lifespan reasoning to bring out what is wrong with Callahan’s proposal to deny any social entitlements to life-extending care for patients beyond the normal lifespan? A prudential planner under a suitable veil of ignorance, deciding whether to make provision or insure for life-extending care beyond the normal lifespan, would consider at least the following: What is the relative frequency of various life-threatening conditions in persons beyond the normal lifespan? What is
the cost of various life-extending treatments for such conditions, and what other goods would have to be generally forgone if those costs are to be borne? What is the expected length and quality of life extension from such treatments, and what is the relative importance of the typical plans and projects that could be pursued or completed during that period of life extension?

It is obvious that a complete analysis would require a great deal of information, much of which we lack in any reliable form. But it is not hard to see that there will be many possible (and actual) cases of life-extending care that a prudential planner would provide for under the conditions of moderate scarcity that obtain in the United States today. To take an extreme example, consider a very healthy and vigorous 82-year-old writer who continues to be actively engaged in several writing projects, has a full and satisfying family life, pursues a number of important community activities for the benefit of others, and greatly enjoys periodic travels. She develops a pneumonia that is life-threatening without treatment, but that can be relatively simply and inexpensively treated with a short hospitalization and course of antibiotics. There is every reason to believe that with prompt treatment there will be no significant long-term impact on her health and that she will be able to return quickly and without any significant deficit or disability to her previous mode of life. Given her otherwise excellent state of health, with treatment she can expect to live another decade.6

Can there be any doubt that a prudential planner would devote the limited resources necessary to secure care in circumstances such as these? If not, then it is equally clear that no general denial of social entitlements to life-extending care for persons beyond the normal lifespan can be derived from the prudential lifespan account of just age-group distribution. And while this case is admittedly extreme in the very substantial benefits promised by treatment at a minimal cost, I believe many other, more common cases would also promise sufficient benefits, given their costs, for a prudential planner to provide for the treatment. (It is unclear why very high benefit/low cost health care is substantially differ-

6. Callahan makes an exception to his proposal for strong age rationing of life-extending treatment for just such a case as this—what he calls “the physically vigorous elderly person” (C, p. 184). But he offers no principled basis for this exception to his general view, noting only that he does “not think anyone would find it tolerable to allow the healthy person to be denied lifesaving care” (C, p. 184).
ent from other high benefit/low cost necessities of life for a healthy person, such as food. It is therefore unclear why Callahan’s reasoning in support of denying to persons beyond the normal lifespan all entitlements to social resources for life-extending *health* care would not apply to the use of social resources for other life extension needs such as *food* as well, though he certainly would not welcome this implication.) Each of the factors that would determine choice varies along a broad continuum, but the closer they get to the area in which a prudent planner would likely judge the benefits of life-extending care not worth the resources it requires, the closer one also is to the cases in which actual persons able to decide about treatment, or to give advance directives about their wishes, would not want the treatment for themselves regardless of whether resources were available to pay for it.

Thus, at current levels of overall resource scarcity in this country, it is not clear that prudent planners with a lifetime fair share of health care resources would exclude coverage for substantial amounts of life-extending health care beyond the normal lifespan. Their attention would better focus, first, on developing and utilizing means of maintaining control over what life-sustaining treatment they receive, especially should they become unable to make decisions about their treatment, and, second, on programs that improve the quality of lives of the elderly. However, while I am skeptical about cost-containment measures narrowly focused on life-sustaining treatment for the elderly, nothing I have said should be taken to indicate opposition to other, differently focused cost-containment measures. These must be evaluated in their own terms, and I believe many are ethically justified. But the shameful inadequacies in many of our social welfare programs, including those designed to ensure that all citizens have basic goods such as food and shelter, as well as health care, are results of failures of political will, not of our failure to adopt strong age rationing of life-sustaining health care.