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I. LIMITATIONS ON ELDERLY ACCESS TO MEDICAL CARE

A. *Introduction*

Health is not an absolute condition, but is assessed by reference to age and other factors. Therefore, a relative scale is necessary to determine whether an elderly person's right to health care is being satisfied.[1] Today, older Americans are increasingly affected by the growing need to regulate health care delivery. Since 1900, those over the age of eighty-five have become twenty-one times more numerous in society, and those over the

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1. *See* Bernard M. Dickens, *Medico-Legal Issues Concerning the Elderly—An Overview*, *in* AN AGING WORLD 487 (John M. Eekelaar & David Pearls eds., 1989).

age of sixty-five have become eight times more numerous.[2] Given the need to curb rising health care costs—particularly expenses related to caring for older individuals—and improve access to health care, society has effectuated two methods of governing the distribution of limited health care resources: allocation and rationing.[3]

B. *Health Care Allocation and Rationing*

The allocation of health care resources involves a societal determination of what resources should be devoted to a particular program.[4] The allocation process is typically performed on a "macro" level, with allocation decisions often affecting only statistical lives.[5] In contrast to the identifiable lives often affected by health care rationing, statistical lives affected by allocation decisions are much more readily sacrificed.[6] A common means of deciding health care allocation is through political processes. Government decisions pertaining to health care spending and regulation typically involve allocation determinations. For example, the Medicare and Medicaid programs allocate resources for numerous purposes.[7] Hospitals, too, regularly make allocation decisions in determining the quantity and type of resources to have available.[8] Their actions, in turn, impact directly upon physicians who subsequently also become health care allocators.

Whether there exists a duty to the elderly citizens affected by such allocation decisions is the subject of much debate. The government arguably does have a duty, based on a collective social obligation, to help people live out a natural life span.[9] Yet, without a limit on investments into health care for the elderly, younger generations will suffer based on an inadequa-

2. Nancy C. Jecker, *Age-Based Rationing and Women*, 266 J. AM. MED. ASS'N 3012, 3012 (1991).

3. *See* David C. Hadon & Robert H. Brook, *The Health Care Resource Allocation Debate: Defining Our Terms*, 266 J. AM. MED. ASS'N 3328, 3328 (1991) (contrasting allocation and rationing); *see generally* Marilyn Chase, *Too Often, the Elderly Don't Get the Drugs or Care They Need*, WALL ST. J., Sept. 24, 1999, at B1 (reporting that the elderly have been undertreated for many medical conditions).

4. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 633 (2d ed. 1991); *see generally* George P. Smith, II, *Accessing Health Care Resources: Economic, Medical, Ethical and Socio-Legal Challenges*, *in* AUTONOMY AND HUMAN RIGHTS ch. 20 (David N. Weisstub & Guillermo Diaz Pinto eds., 2008); George P. Smith, II, *Human Rights and Bioethics: Formulating a Universal Right to Health, Health Care, or Health Protection?*, 38 VAND. J. TRANSNAT'L L. 1295 (2005).

5. A statistical life is the statistical determination of various life and death rates based on the evaluation and computation of numerous factors. FURROW ET AL., *supra* note 4, at 633.

6. *Id.*

7. *Id.*

8. *Id.* at 634.

9. *See* DANIEL CALLAHAN, SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY 137 (1987).

cy of available health care resources.[10] Others argue that individuals should support health care plans allocating fewer resources to health care in old age in exchange for more comprehensive health care earlier in life.[11]

In broad terms, rationing commonly refers to the equitable division of scarce items by limiting the amount to which individuals are entitled.[12] Rationing of medical care is more narrowly defined as the deliberate denial of treatment to some individuals who might benefit from it.[13] The pervasiveness of rationing in the health care industry no longer represents the deliberate, equitable sharing of a scarce commodity. Rather, rationing has come to represent discrimination in access to health care services on the basis of socioeconomic status.

C. *Justifying Age-Based Health Care Rationing*

Proponents of rationing contend that anything short of rationing will lead to an economic catastrophe in America's health care system.[14] Specifically, the proponents argue that rationing is the only way of managing unbridled patient demand, an aging population, and the open floodgates of medical technological developments.[15] They argue that an explicit system of rationing health care services must be implemented to avert a national disaster.[16] This argument, however, is founded on more than mere economic considerations.

Older persons seem particularly susceptible to rationing efforts. Commentators have argued that an integral part of a rationing system is to ration care among the elderly, thereby restricting expensive, high-technology, life-sustaining care for those who have reached a certain age.[17] Implicit in this argument is the principle that elderly health care represents "an investment of scarce resources with few returns."[18] In addition, this argument reflects an intuitive conclusion that an older person has "less

10. *See* Jecker, *supra* note 2, at 3013 (arguing that age-based rationing gives the old and the young equal access to health care resources as they move through life).

11. *Id.*

12. *See* WEBSTER'S NEW WORLD DICTIONARY 1115 (3d ed. 1991).

13. *See* GEORGE P. SMITH, II, LEGAL AND HEALTHCARE ETHICS FOR THE ELDERLY ch. 4 (1996) [hereinafter SMITH, ETHICS]; MARK R. WICCLAIR, ETHICS AND THE ELDERLY 80 (1993) (defining "age-rationing" as denying elderly patients access to health care services).

14. Andrew H. Smith & John Rother, *Older Americans and the Rationing of Health Care*, 140 U. PA. L. REV. 1847, 1848 (1992).

15. DANIEL CALLAHAN, WHAT KIND OF LIFE: THE LIMITS OF MEDICAL PROGRESS 21–23 (1990); Smith & Rother, *supra* note 14, at 1848.

16. Smith & Rother, *supra* note 14, at 1848.

17. *Id.* at 1849.

18. *Id.* at 1849–50.

chance of achieving a successful clinical outcome."[19] Therefore, commentators have made the claim that vast resources are spent on care for the dying elderly and have bolstered this claim with empirical evidence.[20] In further support of age-based rationing, proponents have proffered a wide gamut of benefits, including productivity, equality, natural lifespan, intergenerational justice, and medical benefits.[21]

Others have justified the withholding of costly medical treatment to the elderly on the basis of waning productivity in the later years of life.[22] This argument centers on an investment return theory, suggesting that the dollars spent on elderly health care may better benefit society when invested in patients with greater "potential."[23]

In addition to the greater-investment-return argument, some have suggested that individuals should have the right to live until the same age as others.[24] Proponents of this argument claim that health care services for the elderly should be curtailed in order to allow for such an outcome. By limiting health care for the elderly, services can be provided to allow all, to the extent possible, to reach a certain age.[25]

Others have justified age-based health care rationing on the basis of intergenerational justice and a "natural lifespan" view. Supporters of this view articulate the theory that health care costs for the elderly invariably deprive younger generations of access to adequate health care and thereby limit their exposure to other life experiences.[26] According to this theory, the elderly should recognize that their own welfare is the result of other generations' hard work and that their health care needs are therefore inferior to those of younger generations.[27]

D. *Arguments Against Age-Based Rationing*

Some may argue that health care services should not be rationed at all, particularly not on the basis of age. Proposals in support of age-based ra-

19. Jessica Dunsay Silver, *From Baby Doe to Grandpa Doe: The Impact of the Federal Age Discrimination Act on the "Hidden" Rationing of Medical Care*, 37 CATH. U. L. REV. 993, 1014–15 (1988).

20. Smith & Rother, *supra* note 14, at 1848–50.

21. *Id.* at 1852.

22. *Id.* at 1853.

23. *See* JOHN F. KILNER, WHO LIVES? WHO DIES?: ETHICAL CRITERIA IN PATIENT SELECTION 79–80 (1990).

24. Smith & Rother, *supra* note 14, at 1853.

25. KILNER, *supra* note 23, at 83–84.

26. Smith & Rother, *supra* note 14, at 1853–54.

27. *See* Daniel Callahan, *Health Care Struggle between Young and Old*, SOCIETY, Oct. 1991, at 29, 31. *But see* Vernon L. Greene, Editorial, *Human Capitalism and Intergenerational Justice*, 29 THE GERONTOLOGIST 723 (1989) (arguing that health care resources should not be shifted from the elderly to children and workers).

tioning do not generally advocate the withholding of all medical treatment from older persons. Rather, such proposals suggest that expensive, aggressive care should be withheld from elderly patients.[28] According to one study, withholding all care for high-cost Medicare decedents would have resulted in a $2.8 billion savings in 1987.[29] While withholding high-cost health care from older patients who are seriously ill may save some money, this savings must be balanced against the cost of ending many lives.

The consistently recurring theme in all of the analyses of age-based rationing centers on defining the value of an elderly person's life. Some argue that excluding the elderly from expensive medical treatment may allow society to realize a greater return for its invested dollars.[30] Moreover, commentators argue that limitations on health care to the elderly will allow for greater equality in the number of life years attained.[31] This position affixes a demeaning, monetary value to an elderly person's life. Regulating access to medical care based on age runs against the egalitarian nature of society and the principle that all human life is sacred and equally deserving of protection.[32]

Another widely discussed justification for rationing life-sustaining health care for the elderly is the "natural lifespan" principle.[33] This proposal attaches a normative average to valuating a person's natural lifespan—calculated to be roughly around the late seventies or early eighties—after which a person should receive only supportive and palliative care.[34] The goal of establishing an acceptable age after which health care should be rationed is an attempt to apply a homogeneous criterion to a very heterogeneous society. The contributions made by elderly citizens to society vary widely and make any attempt to value a human life strictly based on age and natural lifespan very difficult. In addition, although some suggest that the elderly should give priority to the health care needs of a younger generation,[35] intergenerational equality is a two-way street. Although the work and contributions of younger generations provide for much of the older generation's welfare, the sacrifices of the elderly created many of the

28. Smith & Rother, *supra* note 14, at 1850.

29. *See* Dennis W. Jahnigen & Robert H. Binstock, *Economic and Clinical Realities: Health Care for Elderly People*, *in* TOO OLD FOR HEALTH CARE? CONTROVERSIES IN MEDICINE, LAW, ECONOMICS, AND ETHICS 13, 17–22 (Robert H. Binstock & Stephen G. Post eds., 1991).

30. KILNER, *supra* note 23, at 90.

31. WICCLAIR, *supra* note 13, at 90.

32. KILNER, *supra* note 23, at 90.

33. Smith & Rother, *supra* note 14, at 1854.

34. CALLAHAN, *supra* note 9, at 20.

35. Smith & Rother, *supra* note 14, at 1854; *see* GEORGE P. SMITH, II, DISTRIBUTIVE JUSTICE AND THE NEW MEDICINE 32–33 (2008).

resources, opportunities, and services that younger generations now enjoy.[36]

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

A. *In General*

The theory of equal medical treatment corresponds with the proposition that persons with similar health conditions receive roughly the same health care. Given the reality of scarce medical resources, however, society is faced with the obligation of allocating the resources as equitably and efficiently as possible. Thus, the debate is no longer whether health care should be rationed, but rather how to ration it equitably.

The presumption that old age hinders the possibility of favorable medical outcomes may be statistically accurate, but it remains a highly undependable clinical outcome predictor.[37] What must be considered is that older people generally are physiologically and psychologically very different from each other. As such, curtailing treatments pursuant to an arbitrary, age-based policy will not result in the most efficient use of medical resources, and fails to recognize individual human potential.[38]

B. *The Equal Opportunity Argument*

Empirical studies make immediately apparent that, given the rate at which the number of elderly and their needs are increasing, no society has available all the resources necessary to completely fulfill those needs.[39] With age-based rationing, however, the aim of equal access to health care is ostensibly achieved in that, with the passage of time, individuals inevitably move through the various stages of life. Furthermore, the opportunity to live out one's life includes such aspects as work, love, procreation, raising a family, and enjoying life with others.[40] Most aged members of society have experienced these opportunities of life. As such, age-based ration-

36. Greene, *supra* note 27, at 723, 724.
37. Smith & Rother, *supra* note 14, at 1852.
38. *See generally* SMITH, ETHICS, *supra* note 13, at chs. 1, 4.
39. *See* B.J. Soldo et al., *Epilogue: Confronting the Age of Aging in Ethics of Health Policy for Elderly*, 19 SOCIO-ECON. PLAN. SCI. 289, 290 (1985).
40. Jecker, *supra* note 2, at 3013.

ing does in essence provide elder citizens with the same opportunities afforded to younger citizens.[41]

One such age-based rationing plan sets forth the goal of guaranteeing a minimally decent level of health care for all while limiting the private demands of ailing elders. Specifically, the plan proposes to cut off all but the most basic medical care at the age of eighty.[42] This policy would be instituted through the Medicare/Medicaid system and would consistently refuse to fund intensive treatment beyond the established age limit.[43] Proponents of the plan argue that it is both decent and manageable and that only through such an active plan can society avoid a genuinely serious crisis in health care costs.[44]

C. *Elderly Discrimination*

Promoting age-based rationing is detrimental to the elderly because it devalues the status of older people and caters to the values of a youth-oriented culture—a culture in which negative stereotyping based on age is prevalent. Age-based rationing carries the danger of signaling to society that the old are not as respected as the young. In addition, denying life-extending treatment to the elderly may foster the growing trend of unequal respect towards the elderly.[45]

Unequal access to basic goods and services promotes inequality and demeans those who are excluded. Medical treatment, however, cannot be conserved in the same manner as other goods or resources. It is morally unacceptable to ration beneficial health care except in the most extreme of situations. Thus, medical treatment cannot ethically be denied from any predetermined segment of the population based on age. Such a denial could, in essence, deny patients of life itself. The factor determining the propriety of medical treatment should, therefore, be the patient's condition, and not an artificial criterion such as age or status.[46]

41. *Id. But cf.* Soldo, *supra* note 39, at 290 (claiming that the transfer of social resources "[pits] the needs and preferences of one generation against another").

42. Sheryl A. Russ, *Care of the Older Person: The Ethical Challenge of American Medicine*, 4 ISSUES L. & MED. 87, 89–90 (1988).

43. *Id.* at 88.

44. *Id.* at 89; *see generally* George P. Smith, II, *Patient Dumping: Implications for the Elderly*, 6 ELDER L.J. 165 (1998) [hereinafter Smith, *Patient Dumping*].

45. *See* SMITH, ETHICS, *supra* note 13.

46. Russ, *supra* note 42, at 89; Smith & Rother, *supra* note 14, at 1856–57.

III. PATIENT DUMPING

A. *In General*

Although patients in "right to refuse medical treatment" cases have trouble terminating their medical care, many experience difficulty *obtaining* medical care in the first place, because they are refused admission to hospitals. This problem is termed "patient dumping."[47]

Patient dumping, also known as "demarketing of services" or "management of patient mix,"[48] refers to the hospital practice of transferring or refusing to treat persons who are indigent, uninsured, or otherwise undesirable to admit.[49] Patient dumping originated from the common law no-duty rule.[50] This rule provides that hospitals have no duty to admit and treat all patients who seek care, and in some cases, have no duty to even specify reasons for rejecting patients.[51] Hospitals often "dump" patients who arrive at hospital wards without health insurance or with only Medicaid insurance—a program which physicians know provides low reimbursement payments.[52]

The economic pressures placed upon hospitals over the past decade increased the frequency of patient dumping in cases falling under the no-duty rule.[53] This rule and the ability of hospitals to refuse medical treatment have been limited by the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA),[54] and the Emergency Medical Treatment and Active Labor Act (EMTALA)[55]—an amendment to COBRA.

The final analysis will show that the elderly will only be secure from the indignity of patient dumping when society and the health care industry acknowledge their inherent value as an important segment of contemporary American life.

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47. *See* Daniel N. Rosenstein, *Emergency Stabilization for a Wounded COBRA*, 9 ISSUES L. & MED. 255, 255–56 (1993); *see generally* Smith, *Patient Dumping*, *supra* note 44, at 165.

48. Rosenstein, *supra* note 47, at 256.

49. *Id.*

50. Karen J. Treiger, *Preventing Patient Dumping: Sharpening COBRA's Fangs*, 61 N.Y.U. L. REV. 1186, 1191 (1986).

51. *Id.*

52. *See* HEALTH AND SOCIAL POLICY ch. 2 (Marvin D. Feit & Stanley F. Battle eds., 1995).

53. *See* Hines v. Adair County Pub. Hosp. Dist. Corp., 827 F. Supp. 426, 428 (W.D. Ky. 1993).

54. 42 U.S.C. § 1395dd (1994).

55. *Id.* On December 7, 1998, the Department of Health and Human Services Office of Inspector General proposed a patient anti-dumping "guidance" designed to clarify the responsibility of managed care hospitals to provide patients with emergency medical treatment. Notice of Proposed Special Advisory Bulletin, 63 Fed. Reg. 67, 486 (Dec. 7, 1998).

B. *Ethical Obligations to Treat the Elderly*

In a society where the elderly are more susceptible to illness and disability than any other age group,[56] they "ought to command special attention in matters pertaining to health care."[57] Access to hospitals and health care resources are important concerns to them.[58] In fact, many have Medicare, private insurance, or both; however, many others have neither. Just like society as a whole, the elderly population is composed of persons having various income levels, interests, and needs.[59] Even if society's ethical consensus advocated for unlimited access to health care, health care providers would still be unlikely to provide health care to persons unable to pay for it.[60] Patient dumping and access to health care remain prominent issues for the elderly because elderly persons are not typically economically productive.[61] Indeed, the population of elderly is disproportionately impoverished and economically disadvantaged.[62]

Some physicians and patients have adopted a consumerist image of the physician as an independent contractor who sells his knowledge and skill to patients who demand care.[63] This contractual model of medical care[64] overlooks the moral and ethical considerations inherent within an emergency patient-physician situation and belittles the idea that a doctor should make "a correct technological (medical) choice consonant with a patient's needs and desires."[65] In addition, for-profit hospitals face an inelastic demand for services, which contributes ultimately to their unresponsiveness regarding altruistic social winds.[66]

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56. *See* Arthur Caplan, *Ethical Issues and the Care of the Elderly*, *in* IMPROVING THE HEALTH OF OLDER PEOPLE: A WORLD VIEW 675 (Robert Kane et al. eds., 1990).

57. *Id.* at 679.

58. *See* George P. Smith, II, *Our Hearts Were Once Young and Gay: Health Care Rationing and the Elderly*, 8 U. FLA. J.L. & PUB. POL'Y 1, 9–11 (1996).

59. *See* SMITH, ETHICS, *supra* note 13, at ch. 1.

60. *See generally* Catherine K. Cassell, *Health Care for the Elderly: Meeting the Challenges*, *in* LEGAL AND ETHICAL ASPECTS OF HEALTH CARE FOR THE ELDERLY 3, 5 (Marshall B. Kapp et al. eds., 1985).

61. *See* Caplan, *supra* note 56, at 668–73.

62. *See id.* at 675.

63. *See generally* Edmund D. Pellegrino, *Rationing Health Care: The Ethics of Medical Gatekeeping*, 2 J. CONTEMP. HEALTH L. & POL'Y 23, 28 (1986).

64. *See* Bruce Jennings et al., *Ethical Challenges of Chronic Illness*, HASTINGS CTR. REP., Feb.–Mar. 1988, at 51, 58.

65. *See* Daniel A. Moros et al., *Chronic Illness and the Physician-Patient Relationship: A Response to the Hastings Center's "Ethical Challenges of Chronic Illness,"* 16 J. MED. & PHIL. 161, 170 (1991); *see generally* DAVE LINDROFF, MARKETPLACE MEDICINE: THE RISE OF THE FOR-PROFIT HOSPITAL CHAINS chs. 1, 2, 5, 8 (1992).

66. *See generally* Jennifer L. Williamson, *The Siren Song of the Elderly: Florida's Nursing Homes and the Dark Side of Chapter 400*, 25 AM. J.L. & MED. 423 (1999).

Americans should be particularly offended when hospitals "dump" elderly patients because the elderly are recruited to poverty after relatively decent working lives.[67] An elderly person's "social worth" and corresponding health care resource allocation should not be determined by his ability to be a rational consumer[68] by saving money to purchase healthful retirement years. Instead, health care should be allocated by considering the fairness to the persons who need care the most—specifically, the sick and indigent elderly.

When society allows health care providers to operate and profit in any community, an ethic of fairness—which respects the wisdom,[69] self respect,[70] and achievement of the elderly—should be in place and, indeed, controlling.[71] Respect for the dignity and autonomy of elderly patients, as well as the underlying motive to help them, must replace the all-consuming profit motive held by both hospitals and physicians as the lodestar for American health care delivery. In order to reach this goal, society should restrict medical licenses to health care providers who will care for the indigent elderly as a condition for doing business with the rest of society. Only then might the incidence of dumping elderly patients be diminished.

IV. WHO SHOULD DECIDE?

The ultimate decision on the merits of age-based rationing and the provision of life extending care is directly linked to society's perception of health care for the elderly and society's medical capabilities. This decision-making process inevitably introduces value considerations into policy formulations—specifically, the allocation of expensive health care resources for the elderly. Allowing values to be a factor may ultimately hinder the resource allocation planning process. Safeguarding the personal values of older Americans may require such a compromise.[72]

Formulating a national policy on health care requirements of the aging leads to inevitable value conflicts. A common perception is that the transfer of social resources essentially polarizes the younger and older generations.[73] Nevertheless, such an intergenerational clashing of interests must not be viewed as an obstacle. Rather, the rational resolution of competing

67. *See* Ronald Bayer & Daniel Callahan, *Medicare Reform: Social and Ethical Perspectives*, 10 J. HEALTH POL. POL'Y & L. 533, 536 (1986).
68. *See* Caplan, *supra* note 56, at 668.
69. *See* JOHN RAWLS, A THEORY OF JUSTICE 440 (1971).
70. *See* SMITH, ETHICS, *supra* note 13, at ch. 1.
71. *See id.* at chs. 2, 12.
72. *See generally* Alfred F. Conard, *Elder Choice*, 19 AM. J.L. & MED. 233 (1993).
73. Soldo, *supra* note 39, at 289.

health care policy considerations demands that conflicting values be scrutinized and, through some factor, interlinked with one another. It must be remembered that values generally serve as self-justifying ordering-and-selecting principles unless they are critically and impartially evaluated. Thus, regardless of how objective an approach society takes toward constructing an equitable national policy on health care allocation to the elderly, the competing value concerns must be addressed in an orderly, critical, and reasonable way. The tool allowing society to undertake such a critical evaluation is ethics.[74]

Ethics is an unparalleled regulator of value selection and must therefore be factored into the formulation of a national elderly health care policy. The American Medical Association's *Principles of Ethics*, for instance, states that notwithstanding the societal interest in containing health care costs, "concern for the care the patient receives will be the physician's first consideration."[75] The weighing of the ethical aspects of medical decision-making for the elderly would indicate how aggressive treatments or intervention should be in prolonging a life otherwise viewed as having limited potential.[76]

V. CONCLUSIONS

In order to confront the issue of health care rationing for the elderly, society must effectively integrate the disciplines of moral and ethical reasoning with the quantitative formulations of needs and resources. Such an effort, supported by an abundance of public debate and discussion, will result in an equitable policy on elderly health care rationing with long-term viability. However, the greatest danger to avoid is the perpetuation of daily "nondecisions" regarding health care treatment for the elderly. Such "decisions" frequently result in the nontreatment of elderly patients and institutional residents because of an inability to assess effectively the equitable and efficient allocation of scarce health care resources.[77]

The real moral question raised from this debate is not whether too much treatment or too little is offered. Rather, "it is how to optimize the appropriateness of the treatment"; therein lies the moral obligation of

74. *Id.*

75. American Medical Association, CODE OF MEDICAL ETHICS: CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS § 2.09 (1992).

76. Terrie T. Wetle, *Ethical Aspects of Decision Making for and with the Elderly*, *in* LEGAL AND ETHICAL ASPECTS OF HEALTH CARE FOR THE ELDERLY, *supra* note 60, at 258, 266.

77. Soldo, *supra* note 39, at 293.

health care as well.[78] However difficult or tragic the decision to allocate, taking no action is perhaps the most pernicious conduct of all. Society must realize that aging is not a disease, but an inherent part of human life.

78. POPE JOHN XXIII MEDICAL-MORAL RESEARCH & EDUCATION CTR., SCARCE MEDICAL RESOURCES AND JUSTICE 112 (1987).