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**HEALTH-CARE GENERATION WAR**

# Spare the Old, Save the Young

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**I**n the coming years, Daniel Callahan's call to ration health care for the elderly, put forth in his book *Setting Limits*, is likely to have a growing appeal. Practically all economic observers expect the United States to go through a difficult time as it attempts to work its way out of its domestic (budgetary) and international (trade) deficits. Practically every serious analyst realizes that such an endeavor will initially entail slower growth, if not an outright cut in our standard of living, in order to release resources to these priorities. When the national economic "pie" grows more slowly, let alone contracts, the fight over how to divide it up intensifies. The elderly make an especially inviting target because they have been taking a growing slice of the resources (at least those dedicated to health care) and are expected to take even more in the future. Old people are widely held to be "nonproductive" and to constitute a growing "burden" on an ever-smaller proportion of society that is young and working. Also, the elderly are viewed as politically well-organized and powerful; hence "their" programs, especially Social Security and Medicare, have largely escaped the Reagan attempts to scale back social expenditures, while those aimed at other groups—especially the young, but even more so future generations—have been generally curtailed. There are now some signs that a backlash may be forming.

If a war between the generations, like that between the races and between the genders, does break out, historians may accord former Governor Richard Lamm of Colorado the dubious honor of having fired the opening shot in his statement that the elderly ill have "got a duty to die and get out of the way." Phillip Longman, in his book *Born to Pay*, sounded an early alarm. However, the historians may well say, it was left to Daniel Callahan, a social philosopher and ethicist, to provide a detailed rationale and blueprint for limiting the care to the elderly, explicitly in order to free resources for the young [see Daniel Callahan, "Limiting

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Health Care for the Old," *The Nation*, August 15/22, 1987]. Callahan's thesis deserves close examination because he attempts to deal with the numerous objections his approach raises. If his thesis does not hold, the champions of limiting funds available to the old may have a long wait before they will find a new set of arguments on their behalf.

In order to free up economic resources for the young, Callahan offers the older generation a deal: Trade quantity for quality; the elderly should not be given life-extending services but better years while alive. Instead of the relentless attempt to push death to an older age, Callahan would stop all development of life-extending technologies and prohibit the use of ones at hand for those who outlive their "natural" life span, say, the age of 75. At the same time, the old would be granted more palliative medicine (e.g., pain killers) and more nursing-home and home-health care, to make their natural years more comfortable.

Callahan's call to break an existing ethical taboo and replace it with another raises the problem known among ethicists and sociologists as the "slippery slope." Once the precept that one should do "all one can" to avert death is given up, and attempts are made to fix a specific age for a full life, why stop there? If, for instance, the American economy experiences hard times in the 1990s, should the "maximum" age be reduced to 72, 65 — or lower? And should the care for other so-called unproductive groups be cut off, even if they are even younger? Should countries that are economically worse off than the United States set their limit, say, at 55?

This is not an idle thought, because the idea of limiting the care the elderly receive in itself represents a partial slide down such a slope. Originally, Callahan, the Hastings Center (which he directs) and other think tanks played an important role in redefining the concept of death. Death used to be seen by the public at large as occurring when the lungs stopped functioning and, above all, the heart stopped beating. In numerous old movies and novels, those attending the dying would hold a mirror to their faces to see if it fogged over, or put an ear to their chests to see if the heart had stopped. However, high technology made these criteria obsolete by mechanically ventilating people and keeping their hearts pumping. Hastings et al. led the way to provide a new technological definition of death: brain death. Increasingly this has been accepted, both in the medical community and by the public at large, as the point of demise, the point at which care should stop even if it means turning off life-extending machines, because people who are brain dead do not regain consciousness. At the same time, most doctors and a majority of the public as well continue strongly to oppose terminating care to people who are conscious, even if there is little prospect for recovery, despite considerable debate about certain special cases.

Callahan now suggests turning off life-extending technology for all those above a certain age, even if they could recover their full human capacity if treated. It is instructive to look at the list of technologies he would withhold: mechanical ventilation, artificial resuscitation, antibiotics and artificial nutrition and hydration. Note that while several of

these are used to maintain brain-dead bodies, they are also used for individuals who are temporarily incapacitated but able to recover fully; indeed, they are used to save young lives, say, after a car accident. But there is no way to stop the development of such new technologies and the improvement of existing ones without depriving the young of benefit as well. (Antibiotics are on the list because of an imminent "high cost" technological advance—administering them with a pump implanted in the body, which makes their introduction more reliable and better distributes dosages.)

One may say that this is Callahan's particular list; other lists may well be drawn. But any of them would start us down the slope, because the savings that are achieved by turning off the machines that keep brain-dead people alive are minimal compared with those that would result from the measures sought by the people calling for new equity between the generations. And any significant foray into deliberately withholding medical care for those who can recover does raise the question, Once society has embarked on such a slope, where will it stop?

Those opposed to Callahan, Lamm and the other advocates of limiting care to the old, but who also favor extending the frontier of life, must answer the question, Where will the resources come from? One answer is found in the realization that defining people as old at the age of 65 is obsolescent. That age limit was set generations ago, before changes in life styles and medicines much extended not only life but also the number and quality of productive years. One might recognize that many of the "elderly" can contribute to society not merely by providing love, companionship and wisdom to the young but also by continuing to work, in the traditional sense of the term. Indeed, many already work in the underground economy because of the large penalty—a cut in Social Security benefits—exact-

from them if they hold a job "on the books."

Allowing elderly people to retain their Social Security benefits while working, typically part-time, would immediately raise significant tax revenues, dramatically change the much-feared dependency-to-dependent ratio, provide a much-needed source of child-care workers and increase contributions to Social Security (under the assumption that anybody who will continue to work will continue to contribute to the program). There is also evidence that people who continue to have meaningful work will live longer and healthier lives, without requiring more health care, because psychic well-being in our society is so deeply associated with meaningful work. Other policy changes, such as deferring retirement, modifying Social Security benefits by a small, gradual stretching out of the age of full-benefit entitlement, plus some other shifts under way, could be used readily to gain more resources. Such changes might be justified *prima facie* because as we extend life and its quality, the payouts to the old may also be stretched out.

Beyond the question of whether to cut care or stretch out Social Security payouts, policies that seek to promote intergenerational equity must be assessed as to how they deal with another matter of equity: that between the poor and the rich. A policy that would stop Federal support for certain kinds of care, as Callahan and others propose, would halt treatment for the aged, poor, the near-poor and even the less-well-off segment of the middle class (although for the latter at a later point), while the rich would continue to buy all the care they wished to. Callahan's suggestion that a consensus of doctors would stop certain kinds of care for all elderly people is quite impractical; for it to work, most if not all doctors would have to agree to participate. Even if this somehow happened, the rich would buy their services overseas either by going there or by importing the services. There is little enough we can do to significantly enhance economic equality. Do we want to exacerbate the inequalities that already exist by completely eliminating access to major categories of health care services for those who cannot afford to pay for them?

In addition to concern about slipping down the slope of less (and less) care, the *way* the limitations are to be introduced raises a serious question. The advocates of changing the intergenerational allocation of resources favor rationing health care for the elderly but nothing else. This is a major intellectual weakness of their argument. There are other major targets to consider within health care, as well as other areas, which seem, at least by some criteria, much more inviting than terminating care to those above a certain age. Within the medical sector, for example, why not stop all interventions for which there is no hard evidence that they are beneficial? Say, public financing of psychotherapy and coronary bypass operations? Why not take the \$2 billion or so from plastic surgery dedicated to face lifts, reducing behinds and the like? Or require that all burials be done by low-cost cremations rather than using high-cost coffins?

Once we extend our reach beyond medical care to health care, if we cannot stop people from blowing \$25 billion per year on cigarettes and convince them to use the money to serve the young, shouldn't we at least cut out public sub-

sidies to tobacco growers before we save funds by denying antibiotics to old people? And there is the matter of profits. The high-technology medicine Callahan targets for savings is actually a minor cause of the increase in health care costs for the elderly or for anyone — about 4 percent. A major factor is the very high standard of living American doctors have, compared to those of many other nations. Indeed, many doctors tell interviewers that they love their work and would do it for half their current income as long as the incomes of their fellow practitioners were also cut. Another important area of saving is the exorbitant profits made by the nondoctor owners of dialysis units and nursing homes. If we dare ask how many years of life are enough, should we not also be able to ask how much profit is “enough”? This profit, by the way, is largely set not by the market but by public policy.

Last but not least, as the United States enters a time of economic constraints, should we draw new lines of conflict or should we focus on matters that sustain our societal fabric? During the 1960s numerous groups gained in political consciousness and actively sought to address injustices done to them. The result has been some redress and an increase in the level of societal stress (witness the deeply troubled relationships between the genders). But these conflicts occurred in an affluent society and redressed deeply felt grievances. Are the young like blacks and women, except that they have not yet discovered their oppressors — a group whose consciousness should be raised, so it will rally and gain its due share?

The answer is in the eye of the beholder. There are no objective criteria that can be used here the way they can be used between the races or between the genders. While women and minorities have the same rights to the same jobs at the same pay as white males, the needs of the young and the aged are so different that no simple criteria of equity come to mind. Thus, no one would argue that the teen-agers and those above 75 have the same need for schooling or nursing homes.

At the same time, it is easy to see that those who try to mobilize the young — led by a new Washington research group, Americans for Generational Equity (AGE), formed to fight for the needs of the younger generation — offer many arguments that do not hold. For instance, they often argue that today's young, age 35 or less, will pay for old people's Social Security, but by the time that they come of age they will not be able to collect, because Social Security will be bankrupt. However, this argument is based on extremely farfetched assumptions about the future. In effect, Social Security is now and for the foreseeable future overprovided, and its surplus is used to reduce deficits caused by other expenditures, such as Star Wars, in what is still an integrated budget. And, if Social Security runs into the red again somewhere after the year 2020, relatively small adjustments in premiums and payouts would restore it to financial health.

Above all, it is a dubious sociological achievement to foment conflict between the generations, because, unlike the minorities and the white majority, or men and women, many millions of Americans are neither young nor old but

of intermediate ages. We should not avoid issues just because we face stressing times in an already strained society; but maybe we should declare a moratorium on raising new conflicts until more compelling arguments can be found in their favor, and more evidence that this particular line of divisiveness is called for. □