- Role of the base station physician.
- Role of the patient's physician

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CCO-DNR Information
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2. Omnibus Budget Reconciliation Act of 1990. Pub L 101-508, §§ 4206,4751. 42 USC § 1395cc(f)(1) & 42 USC § 1396a(a) (Supp 1991).
3. OBRA § 4206a(2), 42 USC § 1395cc(f)(1)(a)(i),(ii).
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Age-Based Rationing of Health Care

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The U.S. has focused attention on the rising costs of health care coincident with the increasing age of the population. Arguments have been made to overtly ration care to older persons; however, general acceptance of the need to ration scarce resources, whether or not such a policy is actually formalized, can lead to covert rationing. Some overt rationing has already occurred, some of the data put forth to justify that rationing needs to be challenged, and ethical principles need to be applied to provide appropriate and perhaps less costly care.

Given the temporal relationship between the increasing numbers of older people and the nation's attention to the costs of health care, it seems evident that aging is the major determinant of increasing costs. The image of demented oldsters avariciously consuming the legacy of our children springs to mind. An incomplete and biased recitation of health care statistics appears to support this conclusion, leading to serious proposals to ration health care for older people.[1] A careful examination of the facts begins with an acknowledgment of the potential for bias, the willingness to question what appears obvious, and searching beyond those data which serve to support a predetermined conclusion. Decisions about health care must be guided by objective information and by illustrating the ethical and moral principles to enlighten decisions about limits on the public money allocated for people of all ages.

In considering the costs of health care it is easy to be baited into an inter-generational contest, pitting the costs of providing increasingly sophisticated care to increasingly younger, potentially chronically impaired neonates, against the costs of caring for the nation's elders. Although the potential life expectancy of babies as a whole is much longer than that of elders, this is often not true when individual lives are compared. It is also possible to make the argument that elders may have contributed to the public good for many years and are now more deserving of care. However, basing decisions on whether an individual is deserving of care presupposes a wisdom that we may not have yet achieved and is to be strenuously avoided.

The use of public monies or health insurance being used for infertility treatment in a country concerned with overpopulation is certainly questionable. Our culture is one that cherishes children and childhood, at least in the abstract. We are most likely to accept the costs of raising a child and seldom stop to total up the costs of the years of dependency. Are we less likely to appreciate the personal fulfillment, redefinition of productivity and inter-generational significance of old age. The importance of completing psychological development and the rooting of successive generations by the presence of elders is undervalued.

However, in considering the allocation of resources it is futile and intellectually inadequate to pursue the avenues of intergenerational conflict. It should be evident that people's lives are priceless at any age. A fully developed society should be guided by principles equally valid across an age spectrum. A consideration of the allocation of resources requires that we examine the quality of the data, understand the age prejudice that exists in our culture, and be primarily guided by the ethical grounds for limiting care at any age.

Population Aging and Costs

Is there a primary cause-and-effect relationship between the rapid aging of the population and health care costs? People over age 65 today comprise about 12% of the U.S. population and account for one-third of the nation's annual federal health care expenditures, or $300 billion of an estimated $900 billion in 1993.[2] By 2020, when baby boomers will be in their mid to late 70s, the population over 65 is estimated to be 20%, with the actual number of people over 65 doubling from today.

However, when examined closely, less than 10% of the

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increased costs of health care can be accounted for by population aging.[2] Further, while it would appear that 12% of the population is using one–third of all public resources, state and local governments spend 10 times the amount on education and children's programs than are spent in programs benefiting elders, including Medicaid.[3]

Futility and Expensive Costs of Caring for the Dying

It has become a widespread belief that a majority of health care resources are spent on high technology care for elderly people in their last year of life. The facts show that medical costs in the last year of life for people aged 80 and older are less than for younger people. In 1989, 2,150,466 persons died in the U.S. Of these 29% were younger than 65, 22% were aged 65 to 74, 28% were aged 75 to 84, and 21% were aged 85 and older. In one study of 500 persons who died,[4] people over 80 had only half the hospital costs of those at younger ages, and costs for those age 65 to 79 were only slightly higher than for those under age 65. The beliefs about the costs of caring for the dying come from a series of papers[5-6] showing that about 30% of Medicare costs are spent on about 6% of people who die. However, only 6% of those who died had costs higher than $15,000, and in all age groups, a high proportion of costs are incurred for a small number of beneficiaries who are either sick enough to be at risk of dying or who are chronically ill. This is not an exclusive old-age phenomenon.[7]

There is also the argument that precious health care resources are squandered on demented elders who would be better off dead and that caring for older people is generally not only expensive, but futile.

Although the exact prevalence of dementia is still to be determined, it probably is present in 10% of people over age 65. It increases in prevalence with age, so that those over 85 estimated to have dementia, ranges between 30% to 50%. Conversely, then from 50% to 70% of people over age 85 are not demented. Even in those who have dementia, with forgetfulness and disorientation as prominent features, the quality of life can be quite acceptable with proper assistance. Those whose lives are more burdensome than pleasurable would be best served by providing care according to their self–determined wishes and advanced directives than by an external application of rationing standards. Although advanced directives, such as living wills, have been developed to further autonomy and privacy, early studies of costs are beginning to show a substantial savings without needing to impose rationing.[8]

If the costs of care is actually spread over an entire age spectrum, it still appears to be intuitive that there would be poorer outcomes of treatment in people of advanced age. Again, we see the value of hard data. In numerous studies of outcomes from surgical procedures and renal dialysis,[9] counter to intuition, chronological age drops out as an independent predictor of results of treatment. Outcomes are more closely tied to co–morbidities and functional status. Previous studies on the results of cancer treatment showing poorer outcomes in older patients have now been shown to be flawed by a systematic undertreatment of elders. Although age may be a marker for co–morbidity and poorer functional status, the results of these studies underline the need to assess individuals one–by–one for appropriateness of treatment and caution against an across–the–board age exclusion.

Overt Rationing

Despite the lack of data to support age–based rationing of care, it is common to hear or read comments about holding down health–care costs by overtly withholding high–tech, high–cost services for older people. There are no data to support chronological age as an independent criterion. There is also the concern that a limitation of high–tech care will lead to a limitation of all care, the *slippery-slope* phenomenon. Only a few months ago, British newspapers were focused on the story of a 73–year old man who refused physiotherapy for arthritis. Subsequently, the Royal College of Physicians published its study of equity care for the elderly. They declared, "there is no biological rationale for separating older people from the rest of the human race: They should get the same quality of care as anyone else." In both the U.S. in the 1960s and in Great Britain until the 1980s there is a history of people over age 45 being excluded from renal dialysis.[10] Subsequently, this age was gradually increased. In the early days of renal dialysis, in both places, with few resources to offer, an age bias was overt. It was assumed that older people would have a reduced life expectancy and derive less overall benefit from treatment. Subsequent information has shown that as a group, older people do have a shorter life expectancy in treatment, but after careful study, the Institute of Medicine Committee for the Study of the Medicare ERSD (End–Stage Renal Disease) Program[11] has specifically rejected age as a criterion for patient acceptance to dialysis, noting that co–morbidities and functional status are the primary predictors of benefits from treatment, not age. Data influencing the decision include, as predicted, that 1–year and 5–year survival of people on dialysis decreases with age. However, this is to be expected, since they note, older people on or off dialysis have a shorter life expectancy than younger people. In addition, the likelihood that intercurrent major medical events will occur is greater in the elderly, leading to a greater prevalence of older people voluntarily choosing to go off dialysis and dying from withdrawal of dialysis. However, whereas there is a reduced life expectancy, studies have shown that older people may value their continued lives on dialysis greater than younger people, with a higher well–being index, more positive feelings, and a greater life satisfaction in general, including being more satisfied with their marriages, family live, savings and investments, and standard of living.[12]

Covert Rationing

As carefully as we must defend against unwarranted overt age–based rationing, we must be ever more vigilant against covert rationing. Consider the following actual case:

A 75 year–old married man in overall good health except for mild emphysema chooses to be admitted to a long–term care facility with his wife who has severe, crippling arthritis and frail health. They have been married over 50 years and he would rather be admitted to a nursing home to be with her than remain at home alone. In addition, the nursing facility is run by a religious organization and offers the further opportunity to study and to live his faith and culture. While at the facility, he happens upon a friend receiving cardiopulmonary resuscitation. He is frightened by the event, and counseling him presents the opportunity to discuss advance directives. After careful consideration, with lots of questions asked and answered, he decides that his life is of high quality, that he wishes to received medical

intensive care if he should ever need it, but without chest compressions. Some time later, he suffers a relatively uncomplicated inferior myocardial infarction and is transferred to the hospital. He is expected to recover fully, but, because of the emphysema and some respiratory fatigue, it is decided to "rest him" for a short while with elective pulmonary intubation. He fully agrees to this plan with the stipulation that if weaning cannot be accomplished easily within a few days, that he not be allowed to remain on the ventilator indefinitely. According to hospital policy, the intensive care unit medical director, who does not know the patient, becomes the attending physician of record. The next day he is visited by his primary physician who finds him extubated, cyanotic, and near death, having been discharged from the intensive care unit. The following explanation is offered the primary physician by the unit resident trainee on duty the previous night who decided, without consultation, to extubate the patient. "Our society cannot afford to keep these elderly nursing home residents alive indefinitely. Besides, he's a "no code" patient, what's he doing in an ICU?" The patient died shortly thereafter, leaving a grieving wife who fully expected to have him back with her within a few weeks and a stunned family and primary physician who were not consulted in the ICU decision.

While there are many aspects to criticize about this case, among them the lack of supervision of the unit trainee, the lack of consultation with the family and primary physician, the main factor at work was age discrimination. In–depth discussion with this misinformed and dangerously unsupervised trainee revealed a person who was both lacking in judgment and profoundly influenced by the comments he heard and read about the cost and futility of health care in the elderly.

Covert actions to withdraw care are dangerous, must be anticipated and must result in policies to prevent such errors. Even more dangerous are the more covert, less dramatic, case–by–case decisions that erode options presented to older people. These may either be well–intended, based on the erroneous belief that they will fail to have an acceptable outcome, or related to an excessive concern for costs. There also is a growing concern that the pressure to tightly control costs in managed–care settings will result in the limited marketing of these plans to older people or stay the hand of care once these individuals are enrolled.

Privacy, Self–Determination, and Autonomy versus Utilitarianism

The concerns regarding costs and rationing are usually phrased in the context of the allocation of limited resources among individuals of a group. In cultures where the autonomy and rights of the individual are a strong priority, the discussion of allocation of resources is unsettling. In utilitarianism, the interest of an individual are secondary to the interests of the group. In some cultures, utilitarianism prevails and different decisions are made. Despite the current substantial percentage of the national resources allocated to health care, some would question whether we are near the actual limits of the resources. They raise the "guns vs butter" argument; comments such as "...the cost of stealth bombers" are heard. Given that the resources available for health care do have some reasonable limit and that we will fast approach it, the argument about allocation rages. The issue at hand is to control costs within an acceptable ethical and cultural framework.

There is every reason to believe that self–determination and autonomy can prevail while, at the same time, costs are reduced by focusing on providing the most appropriate care. This requires a careful assessment of individuals, their needs and probable outcomes of care, without financial or other incentives to provide more care. Promoting self–determination and autonomy while containing costs also requires a systematic way to encourage patients to understand and to choose the extent of care they desire, informed by the best available data.

Care should be appropriate, not rationed. Appropriate care requires that decisions to accept or reject care be truly informed with good facts, the tendency to an age bias be recognized and confronted, and advanced directives and health proxies or surrogate decision–makers be explained and recommended for adults of all ages. Health policy must be such that the possibility of overt or covert rationing to people of all ages who are at risk of needing high-cost care be acknowledged and avoided.

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