Rationing Health Care on the Basis of Age:
Is This the Future of American Health Care?

by Thomas Halper

The British experience has implications for health care policy in the United States and other industrialized countries trying to meet growing demands with limited resources.

Americans of a certain age may well remember ration booklets from World War II. The war so dominated the nation's productive capacity that little remained for ordinary consumer goods, which in consequence were quite scarce. If price had been left to the normal play of supply and demand, many of these goods could have been afforded only by the well-to-do. The political leadership considered this unjust—and, in a democracy where the non-well-to-do vote, politically explosive—so prices were kept moderate, and the right to purchase was allocated by the government in the form of the familiar ration booklets.

Rationing is a means of allocating goods and services at below market prices, and the World War II experience conforms closely to the classic rationing situation: a widely demanded good or service in severe shortage as a result of a temporary crisis; a central rationing agency implementing a consistent policy on a society-wide basis; and a public knowledgeable about the rationing system and broadly supportive of its imposition. The spur was not the desire for justice—but the more mundane and potent sense of injustice: ordinary citizens would feel themselves at such an unfair disadvantage in bidding for scarce goods in the wartime free market that government felt compelled to create a more defensible allocation system.

Yet, rationing need not follow the World War II model, and, indeed, may take a thousand forms. Goods and services may be allocated according to criteria of need, merit, or virtue—or on such unsavory bases as bribery, threat of physical violence, or racial and ethnic prejudice. And allocations may go to named individuals, classes of persons, or to the society at large.

The United States allocates a considerable portion of its health services at below market prices, mainly through Medicare and Medicaid, the chief government programs for funding health care for the aged and the poor, respectively. Millions of patients, as a result, obtain medical care at a fraction of its true cost. But at the same time that government devises and implements general rationing policies, individual physicians make individual treatment decisions. Different physicians, however, may treat similar patients in different ways, reflecting differences in training, temperament, interests, and a number of other medical and nonmedical factors—and these differences are likely to persist so long as physicians retain their autonomy and distinctive individuality. Often, the society level and physician level decisions harmonize, as when a Medicare regulation stops hospital reimbursement in the case of a patient whose physician agrees is ready to go home. Sometimes, however, the sound is dissonant, as a regulation—dictated by government's conception of good medical practice or a desire to save money—conflicts with a physician's judgment—dictated by his conception of good medical practice or a desire to make money. A considerable degree of such tension is probably unavoidable (and perhaps useful, too). But there is no question that the overall consistency of the system is compromised as a result.

Rationing of health care for the aged, in any case, is vastly different from the wartime rationing of, say, automobile tires. For one thing, wartime rationing was acknowledged and its rationale and workings exposed to public view. It could, therefore, be analyzed and criticized, and officials responsible for its creation and implementation could be held accountable for their actions. And accountability is the very hallmark of democracy.

But since the war, the United States has been slow to rediscover the rhetoric of rationing. Seduced by fantasies of ever-rising economic graph lines and mesmerized by advertising images of luxury and abundance, many Americans resist talk of scarcity as a
patient does bad news. All this has staved off comprehension of what has really been happening, but the days of staving off may be about to run out. And then what? A truer, surer grasp of reality, of the inescapable fact of scarcity? Perhaps. Surely, after over a decade and a half of struggle for tens of millions of lower-income Americans, scarcity will hardly be news to everybody. Yet, even now there remain many for whom an appreciation of scarcity has been bred out, as seeds have been almost eliminated from certain fruits. And so rationing of health care for the aged is nearly always met with official denial, though the media have lately begun to warn that rationing "may not be far off" or "may become necessary."

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Looking for candor from the more visible health officials, however, is frequently like expecting a diamond as the prize in a breakfast cereal box. For, of course, the access of the American elderly to medical goods and services at below market prices is already subject to a long list of limitations: "diagnosis related groups" determine Medicare reimbursement to hospitals and routinely trigger discharges; Medicare-supported home health care is narrowly confined; and so on and so on. Nor is this rationing a temporary tide-me-over answer to a passing emergency, like the wartime tire shortage. Rather, it is a general response to a problem so long-term that no serious observer can today see its end. Those straining to keep rationing distant, therefore, strive to maintain a world that does not exist, except in daydreams or ideology.

Notwithstanding all the tedious rhetorical evasions, the question remains: ought health care to be rationed on the basis of age? A first reaction might be "Of course not. Health care should be allocated on the basis of medical need. Age is irrelevant, and should be no more determinative than hair color or astrological sign." Reinforcing this is the fact that the aged, medically, are the most heterogeneous stratum of population, particularly the aged between 65 and 74. Geriatricians, in fact, often speak of "biological" and "chronological" ages because the two are synchronized so poorly.

Consider, in this regard, the British experience with end-stage renal disease, a chronic kidney condition that is nearly always fatal. Though matters have changed considerably in recent years, practice for a long time was simply not to offer treatment to older patients (defined variously as over ages 50, 55, 60, or 65), who as a result died. The rationing was implicit and unacknowledged, usually calling for deception from the doctor and passivity from the patient and his family. There was no national policy document to point to, and significant variations in treatment patterns could be found from district to district. In short, the rationing was far removed from the practice of classic wartime rationing: it was neither explicit nor temporary, consistent nor widely supported.

Older patients in Great Britain were denied care because of a complex of mutually reinforcing beliefs: they were seen as more expensive to treat, their prognosis was usually poorer, their economically productive years were thought to be behind them, and they had already lived a relatively long life. It was not that older patients were deemed unworthy to live, but rather that in a context of serious scarcity they were graded as less worthy than their younger competitors.

For many years, regardless of the political party in power, treatment rates grew only by small increments, as Great Britain lagged behind comparable Western European countries by ever increasing margins. In the mid-1980s, however, the Thatcher government proposed major changes in the National Health Service for which it was widely attacked as heartless and insensitive. Given the enormous public support for the health service and the government's obvious vulnerability to these attacks, it found it useful to target a few afflictions for special attention, as symbols of its compassion and commitment to the NHS. End-stage renal disease had by this time gained considerable public visibility—largely as the result of the efforts of the indomitable leader of the principal patients' organization—so it became one of the afflictions selected to receive more resources. In all this, British age-based organizations played no role.

One question provoked by the British experience is whether age should properly be considered a medical criterion. There is no question that, in general, advancing age has important negative implications for kidneys, and that treatment for older patients is more complicated, expensive, and problematic. It makes sense, therefore, for physicians to use age in a "soft" fashion that alerts them to a congeries of difficulties. Too often, however, Britain's general practitioners and internists used age in a "hard" fashion as a more or less rigid boundary that settled questions of treatment.