Callahan maintains that, because health-care resources are scarce, elderly individuals who have lived a natural life span should be offered care that relieves suffering but should be denied expensive life-prolonging technologies. In arguing for his position, Callahan stresses the need to reexamine questions about aging and the proper ends of medicine, as well as the concept of a natural life span. He concludes
that medicine should have two goals as it confronts aging: (1) averting premature
death, that is, death prior to the completion of a natural life span, and (2) relieving
suffering, rather than extending life, after that natural span has been completed.

In October of 1986, Dr. Thomas Starzl of the Presbyterian-University Hospital in Pittsburgh success-
sfully transplanted a liver into a 76-year-old woman. The typical cost of such an operation is
over $200,000. He thereby accelerated the extension to the elderly of the most expensive and most
demanding form of high-technology medicine. Not long after that, Congress brought organ transplan-
tation under Medicare coverage, thus guaranteeing an even greater extension of this form of life-saving
care to older age groups.

This is, on the face of it, the kind of medical progress we have long grown to hail, a triumph of
medical technology and a new-found benefit to be provided by an established entitlement program.
But now an oddity. At the same time those events were taking place, a parallel government campaign
for cost containment was under way, with a special targeting of health care to the aged under the
Medicare program.

It was not hard to understand why. In 1980, the
11% of the population over age 65 consumed some
29% of the total American health care expenditures
of $219.4 billion. By 1986, the percentage of con-
sumption by the elderly had increased to 31% and
total expenditures to $450 billion. Medicare costs
are projected to rise from $75 billion in 1986 to
$114 billion in the year 2000, and in real not in-
flated dollars.

There is every incentive for politicians, for
those who care for the aged, and for those of us on
the way to becoming old to avert our eyes from
figures of that kind. We have tried as a society to
see if we can simply muddle our way through.
That, however, is no longer sufficient. The time
has come, I am convinced, for a full and open
reconsideration of our future direction. We can not
for much longer continue on our present course.
Even if we could find a way to radically increase

the proportion of our health care dollar going to
the elderly, it is not clear that that would be a good
social investment.

Is it sensible, in the face of a rapidly increasing
burden of health care costs for the elderly, to press
forward with new and expensive ways of extending
their lives? Is it possible to even hope to control
costs while, simultaneously, supporting the innova-
tive research that generates ever-new ways to spend
money? These are now unavoidable questions.
Medicare costs rise at an extraordinary pace, fueled
by an ever-increasing number and proportion of the
elderly. The fastest-growing age group in the United
States are those over the age of 85, increasing at a
rate of about 10% every two years. By the year
2040, it has been projected that the elderly will rep-
resent 21% of the population and consume 45% of
all health care expenditures. Could costs of that
magnitude be borne?

Yet even as this intimidating trend reveals itself,
anyone who works closely with the elderly recog-
nizes that the present Medicare and Medicaid pro-
grams are grossly inadequate in meeting the real and
full needs of the elderly. They fail, most notably, in
providing decent long-term care and medical care
that does not constitute a heavy out-of-pocket drain.
Members of minority groups, and single or wid-
owed women, are particularly disadvantaged. How
will it be possible, then, to keep pace with the grow-
ing number of elderly in even providing present lev-
els of care, much less in ridding the system of its
present inadequacies and inequities—and, at the
same time, furiously adding expensive new tech-

nologies?

The straight answer is that it will not be possi-
ble to do all of those things and that, worse still, it
may be harmful to even try. It may be harmful
because of the economic burdens it will impose on
younger age groups, and because of the skewing of
national social priorities too heavily toward health
care that it is coming to require. But it may also be
harmful because it suggests to both the young and
the old that the key to a happy old age is good health care. That may not be true.

It is not pleasant to raise possibilities of that kind. The struggle against what Dr. Robert Butler aptly and brilliantly called “ageism” in 1968 has been a difficult one. It has meant trying to persuade the public that not all the elderly are sick and senile. It has meant trying to convince Congress and state legislatures to provide more help for the old. It has meant trying to educate the elderly themselves to look upon their old age as a time of new, open possibilities. That campaign has met with only partial success. Despite great progress, the elderly are still subject to discrimination and stereotyping. The struggle against ageism is hardly over.

Three major concerns have, nonetheless, surfaced over the past few years. They are symptoms that a new era has arrived. The first is that an increasingly large share of health care is going to the elderly in comparison with benefits for children. The federal government, for instance, spends six times as much on health care for those under 18 as for those over 65. As the demographer Samuel Preston observed in a provocative 1984 presidential address to the Population Association of America:

There is surely something to be said for a system in which things get better as we pass through life rather than worse. The great leveling off of age curves of psychological distress, suicide and income in the past two decades might simply reflect the fact that we have decided in some fundamental sense that we don’t want to face futures that become continually bleaker. But let’s be clear that the transfers from the working-age population to the elderly are also transfers away from children, since the working ages bear far more responsibility for childrearing than do the elderly.¹

Preston’s address had an immediate impact. The mainline aging advocacy groups responded with pained indignation, accusing Preston of fomenting a war between the generations. But led by Dave Durenberger, Republican Senator from Minnesota, it also stimulated the formation of Americans for Generational Equity (AGE), an organization created to promote debate on the burden to future generations, but particularly the Baby Boom generation, of “our major social insurance programs.”² These two developments signalled the outburst of a struggle over what has come to be called “Intergenerational equity” that is only now gaining momentum.

The second concern is that the elderly dying consume a disproportionate share of health care costs. Stanford economist Victor Fuchs has noted:

At present, the United States spends about 1 percent of the gross national product on health care for elderly persons who are in their last year of life. . . . One of the biggest challenges facing policy makers for the rest of this century will be how to strike an appropriate balance between care of the [elderly] dying and health services for the rest of the population.³

The third concern is summed up in an observation by Jerome L. Avorn, M.D., of the Harvard Medical School:

With the exception of the birth-control pill, each of the medical-technology interventions developed since the 1950s has its most widespread impact on people who are past their fifties—the further past their fifties, the greater the impact.⁴

Many of these interventions were not intended for the elderly. Kidney dialysis, for example, was originally developed for those between the ages of 15 and 45. Now some 30% of its recipients are over 65.

These three concerns have not gone unchallenged. They have, on the contrary, been strongly resisted, as has the more general assertion that some form of rationing of health care for the elderly might become necessary. To the charge that the elderly receive a disproportionate share of resources, the response has been that what helps the elderly helps every other age group. It both relieves the young of the burden of care for elderly parents they would otherwise have to bear and, since they too will eventually become old, promises them similar care when they come to need it. There is no guarantee, moreover, that any cutback in health care for the elderly would result in a transfer of the savings directly to the young. Our system is not that rational or that organized. And why, others ask, should we contemplate restricting care for the elderly when we wastefully spend hundreds of millions of dollars on an inflated defense budget?
The charge that the elderly dying receive a large share of funds hardly proves that it is an unjust or unreasonable amount. They are, after all, the most in need. As some important studies have shown, moreover, it is exceedingly difficult to know that someone is dying; the most expensive patients, it turns out, are those who are expected to live but who actually die. That most new technologies benefit the old more than the young is perfectly sensible: most of the killer diseases of the young have now been conquered.

These are reasonable responses. It would no doubt be possible to ignore the symptoms that the raising of such concerns represents, and to put off for at least a few more years any full confrontation with the over-powering tide of elderly now on the way. There is little incentive for politicians to think about, much less talk about, limits of any kind on health care for the aged; it is a politically hazardous topic. Perhaps also, as Dean Guido Calabresi of the Yale Law School and his colleague Philip Bobbitt observed in their thoughtful 1978 book *Tragic Choices*, when we are forced to make painful allocation choices, "Evasion, disguise, temporizing . . . [and] averting our eyes enables us to save some lives even when we will not save all."

Yet however slight the incentives to take on this highly troubling issue, I believe it is inevitable that we must. Already rationing of health care under Medicare is a fact of life, though rarely labeled as such. The requirement that Medicare recipients pay the first $500 of the costs of hospital care, that there is a cutoff of reimbursement of care beyond 60 days, and a failure to cover long-term care, are nothing other than allocation and cost-saving devices. As sensitive as it is to the votes of the elderly, the Reagan administration only grudgingly agreed to support catastrophic health care costs of the elderly (a benefit that will not, in any event, help many of the aged). It is bound to be far more resistant to long-term care coverage, as will any administration.

But there are other reasons than economics to think about health care for the elderly. The coming economic crisis provides a much-needed opportunity to ask some deeper questions. Just what is it that we want medicine to do for us as we age? Earlier cultures believed that aging should be accepted, and that it should be in part a time of preparation for death. Our culture seems increasingly to reject that view, preferring instead, it often seems, to think of aging as hardly more than another disease, to be fought and rejected. Which view is correct? To ask that question is only to note that disturbing puzzles about the ends of medicine and the ends of aging lie behind the more immediate financing worries. Without some kind of answer to them, there is no hope of finding a reasonable, and possibly even a humane, solution to the growing problem of health care for the elderly.

Let me put my own view directly. The future goal of medicine in the care of the aged should be that of improving the quality of their life, not in seeking ways to extend that life. In its long-standing ambition to forestall death, medicine has in the care of the aged reached its last frontier. That is hardly because death is absent elsewhere—children and young adults obviously still die of maladies that are open to potential cure—but because the largest number of deaths (some 70%) now occur among those over the age of 65, with the highest proportion in those over 85. If death is ever to be humbled, that is where the essentially endless work remains to be done. But however tempting that challenge, medicine should now restrain its ambition at that frontier. To do otherwise will, I believe, be to court harm to the needs of other age groups and to the old themselves.

Yet to ask medicine to restrain itself in the face of aging and death is to ask more than it, or the public that sustains it, is likely to find agreeable. Only a fresh understanding of the ends and meaning of aging, encompassing two conditions, are likely to make that a plausible stance. The first is that we—young and old—need to understand that it is possible to live out a meaningful old age that is limited in time, one that does not require a compulsive effort to turn to medicine for more life to make it bearable. The second condition is that, as a culture, we need a more supportive context for aging and death, one that cherishes and respects the elderly while at the same time recognizing that their primary orientation should be to the young and the generations to come, not to their own age group. It will be no less necessary to recognize that in the passing of the generations lies the constant reinvigoration of biological life.
Neither of these conditions will be easy to realize. Our culture has, for one thing, worked hard to redefine old age as a time of liberation, not decline. The terms “modern maturity” or “prime time” have, after all, come to connote a time of travel, new ventures in education and self-discovery, the ever-accessible tennis court or golf course, and delightfully periodic but gratefully brief visits from well-behaved grandchildren.

This is, to be sure, an idealized picture. Its attraction lies not in its literal truth but as a widely-accepted utopian reference point. It projects the vision of an old age to which more and more believe they can aspire and which its proponents think an affluent country can afford if it so chooses. That it requires a medicine that is single-minded in its aggressiveness against the infirmities of old age is of a piece with its hopes. But as we have come to discover, the costs of that kind of war are prohibitive. No matter how much is spent the ultimate problem will still remain: people age and die. Worse still, by pretending that old age can be turned into a kind of endless middle age, we rob it of meaning and significance for the elderly themselves. It is a way of saying that old age can be acceptable only to the extent that it can mimic the vitality of the younger years.

There is a plausible alternative: that of a fresh vision of what it means to live a decently long and adequate life, what might be called a natural life span. Earlier generations accepted the idea that there was a natural life span—the biblical norm of three score years and ten captures that notion (even though, in fact, that was a much longer life span than was then typically the case). It is an idea well worth reconsidering, and would provide us with a meaningful and realizable goal. Modern medicine and biology have done much, however, to wean us away from that kind of thinking. They have insinuated the belief that the average life span is not a natural fact at all, but instead one that is strictly dependent upon the state of medical knowledge and skill. And there is much to that belief as a statistical fact: the average life expectancy continues to increase, with no end in sight.

But that is not what I think we ought to mean by a natural life span. We need a notion of a full life that is based on some deeper understanding of human need and sensible possibility, not the latest state of medical technology or medical possibility. We should instead think of a natural life span as the achievement of a life long enough to accomplish for the most part those opportunities that life typically affords people and which we ordinarily take to be the prime benefits of enjoying a life at all—that of loving and living, of raising a family, of finding and carrying out work that is satisfying, of reading and thinking, and of cherishing our friends and families.

If we envisioned a natural life span that way, then we could begin to intensify the devising of ways to get people to that stage of life, and to work to make certain they do so in good health and social dignity. People will differ on what they might count as a natural life span: determining its appropriate range for social policy purposes would need extended thought and debate. My own view is that it can now be achieved by the late 70s or early 80s.

That many of the elderly discover new interests and new facets of themselves late in life—my mother took up painting in her seventies and was selling her paintings up until her death at 86—does not mean that we should necessarily encourage a kind of medicine that would make that the norm. Nor does it mean that we should base social and welfare policy on possibilities of that kind. A more reasonable approach is to ask how medicine can help most people live out a decently long life, and how that life can be enhanced along the way.

A longer life does not guarantee a better life—there is no inherent connection between the two. No matter how long medicine enabled people to live, death at any time—at age 90, or 100, or 110—would frustrate some possibility, some as-yet-unrealized goal. There is sadness in that realization, but not tragedy. An easily preventable death of a young child is an outrage. The death from an incurable disease of someone in the prime of young adulthood is a tragedy. But death at an old age, after a long and full life, is simply sad, a part of life itself.

As it confronts aging, medicine should have as its specific goal that of averting premature death, understood as death prior to a natural life span, and the relief of suffering thereafter. It should pursue those goals in order that the elderly can finish out their years with as little needless pain as possible, and with as much vigor as can be generated in contributing to the welfare of younger age groups and
to the community of which they are a part. Above all, the elderly need to have a sense of the meaning and significance of their stage in life, one that is not dependent for its human value on economic productivity or physical vigor.

What would a medicine oriented toward the relief of suffering rather than the deliberate exten-
sion of life be like? We do not yet have a clear and ready answer to that question, so long-standing, central, and persistent has been the struggle against death as part of the self-conception of medicine. But the Hospice movement is providing us with much helpful evidence. It knows how to distinguish between the relief of suffering and the extension of life. A greater control by the elderly over their dying—and particularly a more readily respected and enforceable right to deny aggressive life-extending treatment—is a long-sought, minimally necessary goal.

What does this have to do with the rising cost of health care for the elderly? Everything. The indefinite extension of life combined with a never-satisfied improvement in the health of the elderly is a recipe for monomania and limitless spending. It fails to put health in its proper place as only one among many human goods. It fails to accept aging and death as part of the human condition. It fails to present to younger generations a model of wise stewardship.

How might we devise a plan to limit health care for the aged under public entitlement programs that is fair, humane, and sensitive to their special requirements and dignity? Let me suggest three principles to undergird a quest for limits. First, government has a duty, based on our collective social obligations to each other, to help people live out a natural life span, but not actively to help medically extend life beyond that point. Second, government is obliged to develop under its research subsidies, and pay for, under its entitlement programs, only that kind and degree of life-extending technology necessary for medicine to achieve and achieve and serve the end of a natural life span. The question is not whether a technology is available that can save the life of someone who has lived out a natural life span, but whether there is an obligation for society to provide them with that technology. I think not. Third, beyond the point of natural life span, government should provide only the means necessary for the relief of suffering, not life-extending technology. By proposing that we use age as a specific criterion for the limitation of life-extending health care, I am challenging one of the most revered norms of contemporary geriatrics: that medical need and not age should be the standard of care. Yet the use of age as a principle for the allocation of resources can be perfectly valid, both a necessary and legitimate basis for providing health care to the elderly. There is not likely to be any better or less arbitrary criterion for the limiting of resources in the face of the open-ended possibilities of medical advance-
ment in therapy for the aged.

Medical "need," in particular, can no longer work as an allocation principle. It is too elastic a concept, too much a function of the state of medical art. A person of 100 dying from congestive heart failure "needs" a heart transplant no less than someone who is 30. Are we to treat both needs as equal? That is not economically feasible or, I would argue, a sensible way to allocate scarce resources. But it would be required by a strict need-based standard.

Age is also a legitimate basis for allocation because it is a meaningful and universal category. It can be understood at the level of common sense. It is concrete enough to be employed for policy purposes. It can also, most importantly, be of value to the aged themselves if combined with an ideal of old age that focuses on its quality rather than its indefinite extension.

I have become impressed with the philosophy underlying the British health care system and the way it meets the needs of the old and the chronically ill. It has, to begin with, a tacit allocation policy. It emphasizes improving the quality of life through primary care medicine and well-subsidized home care and institutional programs for the elderly rather than through life-extending acute care medicine. The well-known difficulty in getting dialysis after 55 is matched by like restrictions on access to open heart surgery, intensive care units, and other forms of expensive technology. An undergirding skepticism toward technology makes that a viable option. That attitude, together with a powerful drive for equity, "explains," as two commentators have noted, "why most British put a higher value on pri-
mary care for the population as a whole than on an abundance of sophisticated technology for the few who may benefit from it."

That the British spend a significantly smaller proportion of their GNP (6.2%) on health care than Americans (10.8%) for an almost identical outcome in health status is itself a good advertisement for its priorities. Life expectancies are, for men, 70.0 years in the U.S. and 70.4 years in Great Britain; and, for women, 77.8 in the U.S. and 76.7 in Great Britain. There is, of course, a great difference in the ethos of the U.S. and Britain, and our individualism and love of technology stand in the way of a quick shift of priorities.

Yet our present American expectations about aging and death, it turns out, may not be all that reassuring. How many of us are really so certain that high-technology American medicine promises us all that much better an aging and death, even if some features appear improved and the process begins later than in earlier times? Between the widespread fear of death in an impersonal ICU, cozened about machines and invaded by tubes, on the one hand, or wasting away in the back ward of a nursing home, on the other, not many of us seem comforted.

Once we have reflected on those fears, it is not impossible that most people could be persuaded that a different, more limited set of expectations for health care could be made tolerable. That would be all the more possible if there was a greater assurance than at present that one could live out a full life span, that one’s chronic illnesses would be better supported, and that long-term care and home care would be given a more powerful societal backing than is now the case. Though they would face a denial of life-extending medical care beyond a certain age, the old would not necessarily fear their aging anymore than they now do. They would, on the contrary, know that a better balance had been struck between making our later years as good as possible rather than simply trying to add more years.

This direction would not immediately bring down the costs of care of the elderly; it would add new costs. But it would set in place the beginning of a new understanding of old age, one that would admit of eventual stabilization and limits. The time has come to admit we cannot go on much longer on the present course of open-ended health care for the elderly. Neither confident assertions about American affluence, nor tinkering with entitlement provisions and cost-containment strategies will work for more than a few more years. It is time for the dream that old age can be an infinite and open frontier to end, and for the unflagging, but self-deceptive, optimism that we can do anything we want with our economic system to be put aside.

The elderly will not be served by a belief that only a lack of resources, or better financing mechanisms, or political power, stand between them and the limitations of their bodies. The good of younger age groups will not be served by inspiring in them a desire to live to an old age that will simply extend the vitality of youth indefinitely, as if old age is nothing but a sign that medicine has failed in its mission. The future of our society will not be served by allowing expenditures on health care for the elderly endlessly and uncontrollably to escalate, fueled by a false altruism that thinks anything less is to deny the elderly their dignity. Nor will it be served by that pervasive kind of self-serving that urges the young to support such a crusade because they will eventually benefit from it also.

We require instead an understanding of the process of aging and death that looks to our obligation to the young and to the future, that recognizes the necessity of limits and the acceptance of decline and death, and that values the old for their age and not for their continuing youthful vitality. In the name of accepting the elderly and repudiating discrimination against them, we have mainly succeeded in pretending that, with enough will and money, the unpleasant part of old age can be abolished. In the name of medical progress we have carried out a relentless war against death and decline, failing to ask in any probing way if that will give us a better society for all age groups.

The proper question is not whether we are succeeding in giving a longer life to the aged. It is whether we are making of old age a decent and honorable time of life. Neither a longer lifetime nor more life-extending technology are the way to that goal. The elderly themselves ask for greater finan-
cial security, for as much self-determination and independence as possible, for a decent quality of life and not just more life, and for a respected place in society.

The best way to achieve those goals is not simply to say more money and better programs are needed, however much they have their important place. We would do better to begin with a sense of limits, of the meaning of the human life cycle, and of the necessary coming and going of the generations. From that kind of starting point, we could devise a new understanding of old age.

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