# Age-Related Rationing of Healthcare

**PHIL 334: Pandemic Ethics**

## Questions about Rationing During COVID-19

**Question**:
Should we be aiming to maximize the sheer **number of lives saved**, ignoring facts about expected life years and quality of life?

**What are features that might matter?**

## Things That (Might) Matter

- What are the patient's **chances of survival**?
- What is the patient's **life-expectancy** (if they survive)?
- What will the patient's **quality of life** be like (if they survive)?
- How **old** is the patient? (Why might this matter?)
- How much **overall happiness** would be produced?

What **else** might matter?

## Review:
QALYs & DALYs
Disability

## Quality-adjusted Measures

**QALYs**
Quality-adjusted life years

A QALY is a combination of health-related quality of life and years of life.

**1 QALY** can represent ...
... one year lived at full health
... two years at health-related quality of life level 0.5
... four years at health-related quality of life level 0.25

**Example:**
Treatment A = 5 years at level 0.4
Treatment B = 3 years at level 0.7

Treatment A results in **2 QALYs**, and
Treatment B results in **2.1 QALYs**.

## The Burden of Disease: DALYs

**DALYs** are a combination of ...
years of life *lost* due to disability
years of life *lived* with a disability

Full health = 0
Death = 1

DALYs represent *harm*.

(Compared to QALYs, the scale is inverted)

**Example:**
Suppose a person at 40 contracts a disease with disability weight 0.5, which kills them at age 50.

Burden of the Disease =
(i) 37 years of life lost
(ii) 10 years with disability at level 0.5

This amounts to **42 DALYs**.

## Disability and Discrimination

**The Disability Discrimination Objection:**

"A severely disabled person will have a much lower QALY ranking than a person in full health and therefore each year they live will have a lower (normative) quality of life ranking. But does this mean that the former person's life is less worth living than the latter's; is it thus *worth less?* This goes against a profound belief, both spiritual and secular, that all lives are equally valuable."

**Discussion Question:** What is the argument here? Do you agree? How could a proponent of Cost-Effectiveness Analysis respond?

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Is **Age-related Rationing** Discriminatory?

BIOETHICS FORUM ESSAY

Why I Support Age-Related Rationing of Ventilators for Covid-19 Patients

by Franklin G. Miller

**Coronavirus: allocating ICU beds and ventilators based on age is discriminatory**

April 22, 2020 7.21am EDT •Updated April 22, 2020 9.29am EDT

As the COVID-19 pandemic has increased the demand for intensive care unit (ICU) beds and ventilators, healthcare systems around the world are looking for ways to allocate these life-saving resources. A **decision-support tool** for NHS staff adds points for age, frailty (depicted with stereotypical images of elderly people), and existing health problems (also **correlated with age**) to determine who gets an ICU bed first. Doctors in **Italy**, **Spain** and **Sweden** have also been prioritising younger over older patients. But is this treatment morally acceptable?

Doctors are not alone in thinking that age can be a legitimate criterion for treating people differently. After all, age is correlated with cognitive ability, including the ability to make sound judgements, which is why we use it to deny children the right to vote and we force airline pilots and air traffic controllers to retire early.

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**Today:**
What are the arguments?
**Next Time:**
Philosophical foundations

# In Defense of Age-related Rationing

BIOETHICS FORUM ESSAY

# Why I Support Age-Related Rationing of Ventilators for Covid-19 Patients

by Franklin G. Miller

## In Defense of Age-related Rationing

Frank G. Miller argues that it can be **morally tolerable** to adopt a policy of rationing that adopts **age as a criterion** (but only if those who must forgo such care receive adequate palliative care).

What is his argument?

**Objection:**
Isn't this age discrimination?

## In Defense of Age-related Rationing

He thinks:

Normally, it's okay for resources to be allocated *first-come-first-served*.

But when demand outruns supply, healthcare rationing becomes morally imperative.

**What criteria should we use?**

"In normal times, outside of a health crisis, intensive care beds and technology are properly allocated first-come-first served. This is unsatisfactory when the existing supply is outstripped by demand, as is occurring, or likely to soon occur, in the Covid-19 pandemic. In such a context, rationing of some sort becomes morally imperative. What criteria should govern access to ventilators?"

## In Defense of Age-related Rationing

Grim **prospects** for elderly patients needing ventilation.

While outcomes data are meager at this point, they suggest a grim prospect for elderly patients needing mechanical ventilation. A single medical center in Wuhan, China described intensive care outcomes for 52 patients. Of that total, 37 patients received mechanical ventilation, and 30 of them, 80%, died during the 28-day follow-up. Of 10 patients aged 70 and older, only 1 survived. A much larger data set reporting outcomes for 1591 patients in ICUs in Lombardy, Italy between February 20 and March 18, 2020, demonstrated considerably higher rates of mortality depending on age: 29% for those 61-70; 40% for those 71-80; and 55% for those 81 and older. However, many patients in those age groups remained in the ICU at the time the study was completed. For the 22 patients aged 81 and over, 12 had died (55%); 2 had been discharged (9%); and 8 (36%) remained in the ICU. If half of those remaining in the ICU in that age group subsequently died, the overall mortality rate would be 73%; if all of them died, it would be 91%.

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What **else** might matter?

## In Defense of Age-related Rationing

Other things being equal, the young have **much more to lose** from death than the elderly.

In addition to older patients having a relatively poor prognosis, the number of years of life that they have had the opportunity to experience supports an age criterion for rationing ventilators. Other things being equal, the young have much more to lose from death than the elderly. I would suggest that an initial age criterion for rationing ventilators when the demand outstrips the supply is a cut-off of 80.Eighty years of age is just above the average life expectancy in the U.S., which is 79 years old. It seems fair to say that people who have reached that milestone have enjoyed an opportunity to live a complete life. On average, not many years of life with relatively good health and functioning are left to those aged 80.

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## In Defense of Age-related Rationing

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## In Defense of Age-related Rationing

Losing a **relatively small chance of survival** and **recovery to a tolerable quality of life** seems to me a reasonable sacrifice in favor of younger patients.

If demand for ventilators keeps growing and further outstrips supply, I believe it could be justifiable as a matter of policy to forgo mechanical ventilation for all patients 70 years of age and older who have a medical condition that puts them at elevated risk of death, such as chronic renal disease, cardiovascular disease, diabetes, and chronic lung disease. Finally, in a yet more dire shortage I believe the age limit could be set at 70, regardless of a patient's overall medical condition. This stringent rationing policy would include me. I view myself as having lived a complete life. Losing a relatively small chance of survival and recovery to a tolerable quality of life seems to me a reasonable sacrifice in favor of younger patients, and consistent with promoting the common good in the extraordinary societal situation posed by the current pandemic.

# **Objection:** That's age discrimination!

## In Defense of Age-related Rationing

**Objection:**
That's age discrimination!

**Response:**
What matters is whether using age as a rationing criterion is "reasonable and fair".

Is it **reasonable** and **fair** to use age in this way?

"Some people will object to my proposal on the grounds that I am endorsing **age discrimination.** But what matters is whether using age as a rationing criterion is **reasonable** and **fair**."

## Coronavirus: allocating ICU beds and ventilators based on age is discriminatory

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# Age-related Rationing is Discriminatory

## Age-related Rationing is Discriminatory

**First Criterion:** Chance of Survival

Bioethicists argue that **poor prognosis** should be the main allocation criterion for treatment during a crisis.

If age correlates with this, then using it is not discriminatory.

**Objection:**
Both sex and race are reliable indicators of poor prognosis for COVID-19 patients.

It would be morally unacceptable to use sex or race for rationing urgent care, regardless of how accurate they are as proxies.

## Age-related Rationing is Discriminatory

**Response:**
Age is importantly different from sex and race.

**How so?**
We will be different ages throughout our lives (but not sexes and races).

**Why does this matter?**
Everyone gets a turn...

"Age may be treated differently from sex or race because **people move in and out of age groups throughout their lifetime**. If an age group is worse off than others, this isn't necessarily a problem as everyone's turn at being discriminated against comes at some point."

## Age-related Rationing is Discriminatory

**Age and Lifespan:**
Treating people differently based on age can be a way of treating people equally across their whole lives.

"A rule that prioritises under-65s for life-saving resources would not be treating over-65s unfairly because they, too, were prioritised when they were younger."

## Age-related Rationing is Discriminatory

**Age and Lifespan:**
Treating people differently based on age can be a way of treating people equally across their whole lives.

**Response:**
This assumes that the resources one has access to remains the same over a lifespan.

"A 76-year-old British male will not have had access to universal healthcare for the first four years of his life, before the NHS was founded (1948). The odds that someone in his generation would die within their first year were higher than they are today. Also, as ECMO (a way of adding oxygen to blood) was not widely used in adults for the first 65 years of his life, **denying him access now does not accomplish equality but exacerbates the inequality of being born before key technological advancements**."

## Age-related Rationing is Discriminatory

**In Conclusion...**

Allocating life-saving resources based on age does increase efficiency. Still, the scarcity in the healthcare system we now have to contend with is not a fact of nature, it is the result of social and political choices. To shift the burden for inadequate planning onto the elderly is to make age-group membership a liability. This is the essence of wrongful discriminatory treatment.

# Next Time:
# Fair Innings and age discrimination