Justice between Age Groups: Am I My Parents' Keeper?

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Must no one at all, then, be called happy while he lives; must we, like Solon says, see the end? Aristotle, *Nichomachean Ethics I:10*

THERE HAVE BEEN GROWING COMPLAINTS ABOUT "ageism" and "age-bias" in various settings in the health care system, especially with regard to long-term care. Moreover, there is a growing perception that age groups are competing for scarce medical and other resources, and that this competition will intensify. These perceptions are heightened because of several factors: We are experiencing a novel demographic situation, that of an older, longer-lived population, and we are doing so in a period of rapid health care inflation coupled with slow economic growth. In such a context, talk about rationing to constrain costs is an important aspect of public policy. Nevertheless, there is little or no philosophical discussion that has addressed the central moral issues: Is rationing by age ever a morally acceptable policy? Indeed, there is little clarity on the more general question: When is a distributive system, like the health care system, age-biased?

Accusations of age-bias and ageism arise in many social contexts, and they are generally modeled on the analogous claims about racial

Milbank Memorial Fund Quarterly/*Health and Society*, Vol. 61, No. 3, 1983
 0160/1997/83/6103/0489-34

discrimination. The general complaint is that the elderly comprise a minority that is systematically treated in morally objectionable ways by a younger majority (Butler 1969). Some, using methods standardly employed to measure the effects of racism, e.g., measures of economic inequality, have suggested that ageism induces even greater inequality than racism or sexism (Palmore and Manton 1973). Others point out that crude, age-related stereotypes are used to rationalize policies, like compulsory retirement, which favor younger cohorts. The same stereotypes notoriously interfere with the delivery of considerate, quality medical care (Butler 1969; Butler and Lewis 1977). Others see age-bias at the root of the problems in our long-term care system, which prematurely and inappropriately institutionalizes the elderly, denying support unless they accept a "sick role" (Estes 1979; Monk 1979). Here the stereotype that to be old is to be ill at once leads to a misestimate of the needs of the elderly and rationalizes the economic incentives for institutionalization which are built into Medicare and Medicaid reimbursement policies (Callahan and Wallack 1981).

Even where the accusation of ageism is not voiced, the perception of age-group competition for resources persists. In our health care system, the demographic shift to an older and longer lived population contributes to the perception that an ever-increasing share of high technology medical services are being used by the elderly. In our system, people over age 65 use services at roughly 3.5 times the rate (in dollars) of those below 65 (Gibson and Fisher 1979; Pegels 1980), and a very large proportion of the "high cost" patients are over 65 (Zuck and Moore 1980). The aged and chronically ill have become major users of dialysis and intensive care (Thibault et al. 1980; Campion et al. 1981). We seem compelled to employ life-prolonging technologies wherever we can, which is more frequently among the elderly.

At the same time, we are blind to the impact such policies have on the health prospects of the young. Thus, in a context of rising costs and tightened public budgets, we are more willing to impose stricter eligibility requirements and budget ceilings on Medicaid, most of whose recipients are poor young women and children, or to cut back on preventive measures, like nutritional programs in the schools or environmental protection regulation and enforcement, than to alter our practices with regard to the chronically ill and dying elderly. Indeed, moral outrage is expressed wherever there is a suspicion that rationing of high technology services by age takes place on anything

but purely medical grounds. The British National Health Service's exclusion of the elderly from renal dialysis (they are often deemed "medically unsuitable") has been so criticized (Caplan 1980).

The charges of ageism and the perception of age-group competition are particularly painful. A competition which pits father and son and mother and daughter against grandfather and grandmother is chilling. After all, we believe, "honor thy father and thy mother." But how much? And how long? Age-group competition threatens traditional values, like duties of children to parents, by eroding our confidence that we understand their limits. Moreover, the problem has taken on a new social form, which goes beyond our traditional moral framework for determining duties to the elderly. Shifting family and demographic patterns have converted a private problem into a public one (Frankfather, Smith, and Caro 1981). This public problem is not only more visible, it is also more pressing, largely because of the worst-case scenario of low birth and growth rates. Similarly, the view that the elderly are entitled to support and deserve it, because of their past contributions to cooperative, productive schemes (Morgan 1976), gives little guidance to answering the question, how much? And other moral notions, like the injunction to respect persons equally (Jonsen 1976), fail in a revealing way to give guidance to the problem of distribution between age groups. Yet these questions about competition for resources must be answered, and they will be answered *either by principle or by default.* So we must look for a principled way to tell when distributive schemes are age-biased or fair.

I formulate more clearly the general question about age-bias and compare it to other sorts of distribution problems in sections I and II. Because birth cohorts are transformed successively into different age groups, and because we are concerned with distributive principles that govern social institutions over time, I formulate a modified "prudential saver" model. Allocations such savers approve will be morally acceptable distributions between age groups (section III). I argue in section IV that the notion of a relative-age opportunity range will play an important part in the deliberations of such a saver. This notion suggests how my "fair equality of opportunity" approach to health-care distribution (Daniels 1981a, 1982) can be spared the charge of age-bias. Indeed, when properly understood, we gain an edge on important resource-allocation issues that underlie many criticisms of the United States health care system and its treatment of the elderly.

In section V, I draw some lessons about the problem of equity between birth cohorts from a brief glance at the Social Security system. Section VI concludes with some important qualifications on how my main argument may be applied.

I. When are Acts, Policies or Institutions Age-Biased?

Analogy to Sex and Race

It is easy to think of cases in which appeals to age are morally wrong in much the way that certain appeals to race or sex are morally objectionable. A policy which cut off voting privileges for the elderly, or required them to take a competency test (on the model of driver recertification tests), would be morally objectionable, though, of course, we *do* allow age to play a role in assigning voting rights to the young. Practices which excluded the elderly from certain kinds of housing would be similarly objectionable. Job discrimination against the elderly—or against a protected age group (say those over 40)—has received attention, though not to my knowledge any sustained philosophical examination. Specifically, hiring practices or other job assignment and wage practices which appeal to age criteria and not competence seem morally objectionable in the way sex or race criteria do.[1] Of course, there is an assymetry here: We do exclude the young (say those under 16) from job eligibility, presumably because there is an overriding social concern that there are better things than working the young should be doing for themselves. But this exception points us to the general issue: Age, like race or sex, seems to be a morally irrelevant criterion for a broad range of contexts.

[1] A qualification may be needed here. Age criteria may not function exactly like race or sex criteria in such contexts. It might not seem imprudent for age-related practices, like seniority, to be given weight. Indeed, from the perspective of a prudent person allocating job opportunity over a lifetime, it might seem worth trading greater training options in one's youth for greater job security in one's later years. No such reference to race or sex criteria is plausible, largely because the prudent saver model allows greater freedom here than where distributions more clearly cross the boundaries between persons. See section II.

To be sure, we have to unpack the notion of moral relevancy if we are to get a useful explanation, and this difficult task is not one I can undertake here. Still, many cases are clear. Race is not an indicator of competency to perform a job and so it is morally objectionable to use it as a guide to hiring practices (except, possibly, in the context of certain compensatory practices, like affirmative action). Age is not an index of the likelihood of being a good tenant and so is morally irrelevant to rental practices. And where some associate a relevant trait (industriousness, intelligence, crankiness) with a generally irrelevant one (race, age), the associations usually are, in the important cases, false; that is, they are part of a racist or sexist myth (Daniels 1976). At best, they are crude, statistical generalizations which will clearly be unfair (by denying fair opportunity) to individuals, about whom the generalization is quite wrong.

Disanalogy to Sex and Race

Though these cases and considerations explain the temptation to draw parallels between the use of age, sex, and race criteria, other cases challenge the analogy. Consider the question in a rationing context which has been criticized as age-biased by many, namely, the policy that existed (at least implicitly) in the British National Health Service of not giving renal dialysis to those over age 65. Let us suppose that dialysis is medically effective for elderly patients, permitting relatively normal functioning, so that the age criterion is not merely a guide to medical suitability. Does the appeal to such an age criterion in rationing constitute an age-bias, by which I mean a morally unacceptable discrimination? Our earlier considerations suggest it does. If the sole difference between two persons, one age 64 and the other age 66, is their age, and that is the basis for deciding who gets dialysis, then it surely looks like the rationing scheme is age-biased in a morally objectionable way.

But the rationing case is more complicated; contrary considerations come to mind. Consider two rationing schemes. Scheme A involves a direct appeal to an age criterion. No one over age 70 is eligible to receive any of several high-cost, life-extending technologies, e.g., dialysis, by-pass operations, or angioplasty. Because age rationing greatly reduces the utilization of each technology, there are resources available for developing all of them. Scheme B rejects age rationing

and allocates life-extending technology solely by medical need. As a result, it can either develop just one such technology, say dialysis, making it available to anyone who needs it, or it can develop several and ration them by lottery. Given our earlier discussion, scheme A seems age-biased in a way that B is not. The effect of B, however, is to reduce the likelihood of people under 65 reaching a normal life span (say, "three score and ten"). Some would contend that scheme B, though it lacks reference to an explicit age criterion, has a systematic negative effect on younger age groups and is, in that sense, age-biased in a morally objectionable way.[2] Of course, the contention depends on showing that maximizing the likelihood of reaching a normal life span is morally preferable to merely extending life wherever we can (without any reference to age). Considered moral judgments differ on this and related issues (and in ways that may reflect our interests given our ages); moreover, there are strong considerations and arguments inclining us in opposing directions. The problem is made to seem even more intractable because these moral disagreements are set in the context of a distributive framework that makes one group's gains look like another group's losses.

Savings Schemes

I would like to suggest a different distributive framework for conceiving the problem, one that permits a fresh theoretical perspective. The perspective can be introduced by observing an important fact about certain health care insurance schemes. Suppose we have a health care financing scheme that guarantees substantial access to medically needed health care services for the elderly. The details of the scheme do not much matter here. It could be a universal national health insurance scheme with subsidization for those who cannot afford premiums, or it could be a composite financing system which included private as well as publicly subsidized programs. But even a scheme that does not redistribute income raises the same issues provided that it is "community rated" and incorporates all ages into one riskpool. The central fact is that health care needs vary with age, so that the elderly

[2] The allocation issues here are numerous. For example, the young might prefer investing in preventive efforts, like health hazard regulation, whereas the elderly may not benefit from such long-term investments.

will use certain health resources at a higher per capita rate than the working-age population. In 1977 the 10.8 percent of the population over 65 incurred 29 percent of the total, personal, medical services bill. Consequently, any such insurance scheme involves a transfer of wealth from later birth cohorts to earlier ones, from younger age groups to older ones. But if the insurance scheme continues over a long period of time, birth cohorts which are now transferring wealth—aid-in-kind—to their elders will eventually be the beneficiaries of such transfers from later birth cohorts. Consequently, any such health insurance scheme can be viewed over time as a savings scheme. Participation in the scheme transfers resources, in the form of contingent claims on health care services, from one's youth to one's old age. Of course, such savings are not "vested" assets, like money in the bank; but we are deferring resources from one point in our lives to another and so have a kind of savings scheme.

Notice how focusing on an institution that operates through time—the insurance scheme—forces a shift in our perspective on the rationing problem. We are driven to convert the synchronic or time-slice distribution problem we first raised—namely, how to ration health care resources between competing groups while avoiding age-bias—into a diachronic perspective in which we are concerned with the treatment of the same people through the various stages of their lives. From this perspective—from my perspective—three questions about the design of the institution—here, the insurance scheme—arise in a quite natural way:

1) At what rate of savings should I defer the use of health care resources within my life?
2) What do I most need and want by way of health care benefits at each stage of my life?
3) How can I be sure that my participation in the scheme involves equitable transfers between by birth cohort and both earlier and later ones, given the fact that economic and population growth rates vary through time?

The last question is familiar, of course, because of current worries about intercohort inequities in the Social Security system, and I shall return to these matters in section V. The answer to question 2 will have a bearing on the answer to 1. I have raised these questions in

the first person. But, because we are concerned with cooperative social schemes, it may be necessary to answer the questions from a more general perspective, that of a prudent saver, or even some more hypothetical construction in which the saver operates behind a "veil of ignorance" of appropriate thickness. I return to this issue in sections II and III. But first I want to return to the rationing problem I posed earlier, using the perspective suggested here.

Prudential Savings

Suppose I know I have available to me a lifetime health care allocation, say in the form of an insurance benefit package. However, it is up to me to budget, once and for all, that allocation or benefit package so that it is used to meet my needs and preferences over my lifetime. How would it be rational for me to budget it—given all the uncertainties about my future health, wealth, and family situation? One plausible proposal might be for me to reserve certain life-extending technologies for my younger years, reasoning that my doing so maximizes the chances of my living a normal life span. I then might use the "savings" embodied in that restriction to provide myself with more social support services in my old age. I might reason that such services could vastly improve the quality of my years in old age and that such an improvement is worth the increased risk of a slightly shortened old age. I might then instruct—through my benefit package—the providers to treat me accordingly, that is to appeal to an age criterion in their utilization decisions concerning me. This package is intended to resemble the age-rationing scheme the British National Health Service apparently used for hemodialysis, and a rationale for the British scheme could be modeled on my reasoning about my package.

Under this scenario, although age is used as a criterion in the utilization decisions involving me and everyone else who joins the same insurance scheme, there is a minimal basis for suggesting my treatment is age-biased in a morally objectionable way. It might be thought that there is no "bias" here merely because I consent—buy into—the scheme. But the fact of my actual consent to the scheme is not the main issue here. Consent does not quite count for everything; Blacks or women might consent to race- and sex-biased treatments without thereby overriding all claims that the treatments are morally

objectionable.[3] As I suggest in the next section, there is an important difference between the age and race or sex distribution problems, and it is this difference that explains why age-rationing in such schemes is not morally objectionable in the way race or sex rationing would be.

We are not in a position to answer the question of when acts, policies, or institutions are age-biased. But we have seen strong reason to think that not every appeal to an age criterion for rationing is as morally unacceptable as comparable appeals to sex or race would be. We must explore further why the cases are different.

II. Does Aging Pose a Distinct Distribution Problem?

Future Generations

The distribution problem between age groups is usefully contrasted with two distribution problems it somewhat resembles. Consider first whether the age-group problem is just a special case of the problem of obligations to future generations. After all, age cohorts are commonly referred to as "generations." And both seem to raise the issue of competition for resources. Present and future generations—just like age groups—compete with each other. The problem of obligations to future generations is also sometimes formulated as the problem of finding a just savings principle. So too the issue of a fair savings principle arises in the age-group problem, at least if we view schemes which transfer income or health care benefits from younger cohorts to older ones as a kind of "savings institution." What rate of transfer, what savings rate, is just? Moreover, there is another point of similarity: Transfer schemes operating through extended periods must be concerned

[3] The issue is quite complicated and arises often in making moral judgments about race, caste, or sex practices in other cultures. Often we try to avoid the issue by discounting consent, say by labeling it "false consciousness." But what if the consent seems genuine? Do such problems make the appeal to Kantian views of the person and hypothetical contracts all the more problematic, or all the more attractive?

that different birth cohorts enjoy equitable "replacement ratios." (The replacement ratio is the ratio of benefits to contributions.) This problem of equity does strongly resemble the just savings problem between generations.[4] Nevertheless, I think the differences between the problems of the aging and future generations are greater than their similarities.

The major difference is that young birth cohorts are transformed in time into elderly cohorts: they age. But no current generation becomes a future generation. It follows that certain special features of the future generations problem do not arise in the aging problem. We do not have to consider the great uncertainties about conditions of life in the very distant future; we do not have to worry about the puzzling conceptual problems that may attend positing obligations by existing people to nonexistent ones. But the most important consequence of this difference between the problems is that some form of prudential reasoning is naturally appropriate to solving the age-group distribution problem in a way that is not appropriate for the future generations problem. I know I will grow old, or at least that I must prepare for the eventuality of growing old. So, I have a concern

[4] It is worth noting a point of contrast between the aging problem posed here and the just savings problem as it is discussed by John Rawls (1971, sect. 44, 45). Rawls is primarily concerned with *preserving* adequate capital and nonrenewable resources so that successive generations are in a position to maintain institutions of justice. In contrast, we are concerned with institutions which transfer income or aid-in-kind between age groups so that their consumption will yield just income-support and health care distributions through our lifetimes. Rawls's approach to the just savings problem involves his device of a thick veil of ignorance: We do not know which generation we will be in when we are choosing our principles of justice. Moreover, he imposes a motivational constraint on parties making the hypothetical contract: They are concerned about the well-being of a generation or two in each direction (from their grandparents to their grandchildren). Contractors operating under such constraints would prudently grant each generation an equal claim on resources necessary to maintaining institutions of justice. In this way the just savings rate acts as a constraint on other principles of justice, such as the difference principle: No society can maximize unless it has set aside the resources required by the just savings principle. Question 3 posed in the last section, about equity in replacement ratios between birth cohorts participating in the scheme, may need for its resolution arguments based on such a hypothetical contractual apparatus. But I think that answers to questions 1 and 2, about the rate of savings and the content of the benefits saved, may be approached more directly, with a less veiled form of prudence. Still, the answer to question 3 will constrain answers to 1 and 2, much as the savings principle constrains the difference principle.

for the structure of institutions that will help me defer the use of resources in a prudent way. In no such direct way does prudence make me concerned about saving resources for future generations. (Of course this contrast will have to be qualified somewhat in the next section since we will ultimately be talking about prudence in a more hypothetical context.)

A further difference between the aging and future-generations problems is that different age groups coexist and compete politically for social goods distributed in cooperative arrangements. Future generations are not here to fight for their interests. This difference may be an important psychological and political fact; it is less clear how relevant it is to the problem of deciding what arrangements are, in principle, just. It does, however, introduce some issues about the implementation of cooperative schemes and the contrast between ideal and nonideal arrangements, to which I return in section V.

Sex and Race

The fact that different age groups coexist and share in a distribution scheme contemporaneously may make the age-group problem resemble more closely the distribution problems among other demographic groups (races, sexes, classes) than it does the future-generation problem. The similarity enhances the sense that we are concerned with a synchronic distribution problem, a time-slice in which competition rages. Moreover, as we saw in section I, many of the same issues arise in all these demographic competitions. The moral arbitrariness of certain appeals to age resembles the arbitrariness of appeals to race or sex. Similarly, we are concerned that our treatment in cooperative schemes should reflect the fact that we are all equally to be considered as persons, regardless of age, sex, race, class, and so on.

But the very same fact that makes the aging problem different from the future-generations problem also makes it different from the distribution problem involving other demographic groups. Young birth cohorts age and are transformed into older age groups. We become old, but we do not change generations, race, sex, or (usually) class. As Zeckhauser and Viscusi (1978, 54) put it: "The elderly comprise a minority group we can all hope to join." This basic fact points to the naturalness of the suggestion that we think about cooperative social schemes which bear on aging in prudential terms, even though

we may have to abstract somewhat from the perspective of a real individual, that is, from the economist's "prudent saver" (q.v. Samuelson [1958] for the classic treatment).

Within vs. between Lives

It is now possible to explain why appeal to an age criterion in some rationing schemes works differently from appeals to race or sex criteria. From the perspective of institutions operating over time, the age criterion operates within a life and not between lives. One important criticism of utilitarianism, advanced by Rawls, is that it extends a principle of individual, rational choice appropriate to distributions within a life into a social principle of rational choice that crosses personal boundaries (Rawls 1971, sect. 5; Parfit 1973; Daniels 1979b). Thus, it is rational and prudent that I take from one stage of my life to give to another, in order to make my life as a whole better. But it is morally problematic just when society can take from one person to give to another in order to maximize, say, total happiness. Rawls's point would explain the deep problem facing any attempt to ration life-extending resources by race or sex. In this case, taking from some to make society as a whole better off would fail to respect the difference between persons. But now we see the difference between the race and aging cases. Rationing by age criteria looks like a case of crossing personal boundaries only if we take a "time slice" perspective. Once we take the perspective of institutions operating through time, the appearance of crossing boundaries between persons fades and we are concerned primarily with distribution through the stages of a life. No comparable point is true for rationing by race or sex over time.

This general point is not to deny that there are some irreducible interpersonal aspects of the cohort issue. For example, the question of equity in replacement ratios between birth cohorts raises an issue of equity between persons in the face of changing economic growth rates or birthrates. This issue aside, however, the core of the age-group problem has a different philosophical texture from either of the other distribution problems we have considered.

The distribution problem between age groups must, of course, be set within a framework that takes more general issues of distributive justice into account. This might suggest there is no special problem of distribution between age groups. One might, for example, think

Rawls proceeds as if there is no special problem of justice. His "difference principle" requires that the worst-off groups are to be made maximally well off, as measured by an index of primary social goods, which includes basic liberties, opportunity, income, wealth, powers, and self-respect. But the value of the index for a representative individual is determined by his share of primary goods over his lifetime; thus, it is to include what social or economic mobility he will enjoy or regret. This lifetime index assignment might suggest that Rawls ignores the problem of distribution between age groups, perhaps dismissing it as a problem for individual savings. But Rawls's simplifying assumption involving the index is not a sleight of hand that makes the problem of distribution between age groups disappear.

The problem we are concerned with reemerges as soon as one tries to arrange basic social institutions that embody the more general principles of justice over time. For then, the problem of rationing income or health care benefits throughout the stages of a life arises again, and this problem requires the establishment of cooperative schemes or institutions of a rather basic sort. The difference principle, to continue with the Rawlsian example, maximizes the index level of representative, worst-off individuals over their lifetimes. But several cooperative "savings" schemes might be compatible with satisfying the difference principle. That is, the more general theory of distributive justice is silent on the age-group distribution problem except where intercohort transfer or savings schemes interfere with the difference principle. Moreover, if I am right that health care institutions should be governed by the fair equality-of-opportunity principle, as I later extend it, then at least this "savings institution" constrains the difference principle.

III. Prudence and Aging

Justice and Prudence

I have been suggesting that we approach the problem of competition—or distribution—between age groups from the perspective of institutions that operate through time to defer resources from one stage of life to another. But in converting what began as an interpersonal distribution problem, with all its attendant worries about age-bias, into an intralife

problem of rational or prudent savings, my approach encounters an objection, one with a paradoxical air about it. The objection is that the shift to talk about prudential allocations of resources within a life, far from telling us when distributions between age groups are just or age-biased, prohibits us from raising the question about age bias at all. For, when a person favors one stage of life over another, his inadequate or inappropriate allocation to one stage of his life—or, in a cooperative scheme, to an age group—is not viewed as immoral or unjust. It is merely imprudent, at worst.

Consider some examples. Olga is a figure skater who has invested very heavily in the development of certain talents and skills while neglecting others. She has ignored the development of critical social skills, acquired only the narrowest education, and led an austere, even grim, childhood and youth. If she achieves wealth and fame in her career—becomes a star of the Ice Capades—then she may feel the gamble has paid off. Later stages of her life will reap benefits from the sacrifices of earlier stages. But what can we say about the extreme hardship and sacrifice she experiences in her childhood? They might be imprudent (even if the gamble pays off). But it seems merely metaphorical to say she was "unfair" to her childhood. So, if the intralife model precludes saying that the plan is unfair to a life stage or biased against it, then it looks like we are not solving the problem we thought existed. Of course, it does make a difference whether the plan for Olga is hers or is imposed by ambitious parents and skating instructors, perhaps even with "false consciousness" on Olga's part. But here the unfairness to Olga is both that she was denied resources and opportunities thought normal to development, and that she was denied autonomy, the chance to design her own life plan.

Consider a case in which Olga's plan is writ large into a social policy, a kind of initiation rite. From age 20 through 30, people are given just a living stipend for the work they do. They accumulate no property and lead austere lives. After the initiation or "social indenture" period, they are presented with an annuity policy which enhances their income at a later stage of life, or they are given some other award, perhaps just acceptance as full-fledged citizens who benefit from the labor of the next birth cohort going through the process. Is such a scheme age-biased? Depending on details, a central complaint might be that the system too severely restricts certain liberties, which we may see as a social good that should not be rationed or "saved"

in this way. But, liberties aside, suppose the system were stable, seemed to reflect a shared conception of a rational plan of life, and appeared to be as voluntary as any well-entrenched social custom involving initiation rites. We might be inclined to say it is imprudent for the indentured cohort to "save" in this fashion; they might disagree. Of course, we might not be able to say even that if the "return on investment" for participation is higher than in alternative schemes. In any case, does our ability to complain about age-bias disappear?

The examples really raise two issues. The first is primarily terminological. Ordinarily, we do not import moral notions, like fairness and justice, into prudential contexts, viz., allocations within a lifetime. But the proposal here is that our proper standard for judging the fairness of distributions between age groups—which do exist as distinct groups of people, in contrast to stages within a life—is prudential. We are to view the different age groups as if they were but stages of one life, for, from the perspective of cooperative "savings" schemes operating through time, each person is treated at the different stages of his life in just the same way the different groups are. Accepting the proposal would be grounds for ignoring the suggestion that the language of prudence bars us from raising issues of justice.

Prudence: Individual and Social

But the examples also point out that what is prudent from the perspective of one rational person or group of persons may not be from that of another. The appeal to a prudential or rational savings model usually carries with it the notion of an individual with a given set of preferences or "conception of the good." What is prudent is so from his conception of the good. How, then, can we use the suggestion that prudential reasoning is the key to solving the distribution problem for different age groups? The social institutions which bear on saving encompass people with different conceptions of the good.

There are two main strategies. One is the proposal that we rely on market mechanisms to allow people every chance to express their own prudent preferences. The social task, then, is to make sure such markets function properly and that income distribution is initially just. Specifically, with regard to health care, one might look to a market for insurance schemes which differed from one another in their "rate of savings" for later stages of life. That is, some might have

lower premiums and offer less coverage in later years; others might defer more resources, in the form of contingent benefits. People would then buy the package that it is prudent for them to buy, given many facts about their situations, including their conceptions of the good, risk averseness, and so on. This approach converts with a vengeance the problem of age-group distribution into an individual savings problem: The social concern is to provide a setting in which individual rationing within lives can take place. But there is little room for social institutions to guarantee that prudent allocation takes place. The second strategy is to modify the appeal to prudential reasoning by using a hypothetical agent, one which abstracts from certain features of individuals. Such an agent, then, seeks principles for the design of the relevant social institutions. I shall suggest a version of the second strategy which is appropriate to the savings problem for health care. In its general form, the strategy is familiar as the hypothetical contractarian approach used by Rawls and others. But it is worth considering some limitations of the first strategy first.

Individual Prudence: A Market Example

The strengths and limits of the first strategy are revealed if we consider the way in which a rational consumer might think about the problem of chronic illness or disability. The long-term care such conditions require is a focal point of criticism of the treatment of the elderly. In our system, chronically disabled or enfeebled persons tend to be institutionalized much more frequently and earlier than comparable persons in other systems, e.g., the British or Swedish. Moreover, they are often institutionalized at inappropriate levels of care, and possibly at higher cost, than alternative forms of treatment or service would involve. The incentives for such institutionalization are built into Medicare and Medicaid reimbursement schemes. The effects of such overmedicalization are serious, on both the mental and physical health of the elderly (Morris and Youket 1981). Yet, as Christine Bishop (1981) points out, the uncertainty facing the onset and costs of disability make it an obvious candidate for insurance schemes. (I draw on Bishop in the next three paragraphs.) The rational consumer would presumably try to buy a package that avoided the features of our current long-term care system.

Any individual faces a significant, actuarially calculable chance of

chronic illness or disability over his lifetime; the chance increases with age (let us leave aside those disabled from birth or facing a known genetic disposition to disability). Though only one in twenty persons over 65 is in a nursing home in a given year, one in four will at some time enter one (Palmore 1976). Chronic illness or disability may require large expenditures for medical, personal care, or social support services. Moreover, the size of the expenditures for a given disability will vary with other contingencies, such as family situation and preferences for living conditions. The uncertainty surrounding each of these contingencies and their joint risk suggests that the rational consumer will enhance his well-being over his lifetime if he pays a modest insurance premium rather than keeping the money and risking a large loss. Specifically, we might expect rational consumers to want insurance schemes which offered them benefits flexible enough to meet their real needs. They would want alternatives to nursing home institutionalization if they needed lower levels of care, or some family help, or modifiable living quarters. Thus, they would buy contingency claims on the joint risks of disability and other factors, such as the absence of family support or the unsuitability of living arrangements.

The connection between disability as an insurance problem and as a problem of "savings" becomes clear when we see, as Bishop notes, that short-term coverage faces special problems. If coverage is actuarially fair and we risk-pool by age, then high premiums will face the elderly, those most in need of the insurance and those least likely to be able to pay for it because of declining incomes. The prudent consumer, anticipating such higher premiums, would have to save, perhaps by buying an annuity to cover his later premiums. But since he does not know how long he will live, to 100 or to 66, it is hard to predict how much to save. Notice, however, that plans offering lifetime coverage with a fixed premium are equivalent to such savings; a community-rated lifetime plan has a built-in savings feature because of the distribution of needs by age.

Though these considerations suggest that there should be a demand for such insurance, we find no market offering it. Bishop points to several reasons for market-failure: 1) uncertainty about inflation adds to the insurer's risk, where real benefits and not fixed dollar amounts are involved, so private coverage would be discouraged; 2) administration costs are high if coverage of the population is not extensive; 3) some

current public programs would partially undercut the market for such insurance; and 4) "adverse selection" (which means too many high-risk people buy, driving premiums up and low-risk people out) and "moral hazard" (e.g., in the form of overstating disability) are especially likely for these forms of insurance. From these facts, Bishop concludes that private marketing of such insurance is not likely to develop and that some form of universal, compulsory insurance should be instituted, for which she considers several different proposals.

Bishop's proposal for a unified national insurance scheme for long-term care, encompassing medical, personal care, and social support services, is surely a step in the right direction. Moreover, her discussion of the scope and content of the lifetime-coverage scheme is informed by prudent considerations, which I earlier suggested were necessary to undercut the issue of age-group competition. The scheme continues through time so that the young who pay higher premiums (or taxes) now will in due time be beneficiaries of such "savings," through the similarly higher payments of later birth cohorts.

Still, there is a gap in her argument: The social obligation to provide such compulsory coverage does not follow from the fact of private market failure alone. Nor does it follow from the fact that net well-being might be greater if the public scheme were instituted, for there are many public schemes that might enhance net well-being. We need some argument that the social good protected by such a cooperative social scheme is specially important, say, because it is a social good that gives rise to claims of justice. Schemes such as the one Bishop discusses involve a significant income redistribution. Entitlements to benefits, presumably at an "adequate" level, will be subsidized for those who cannot buy them. But what determines that level? And why should those who are better off be willing to provide it? Moreover, as long as we are considering such insurance schemes from the perspective of the prudent agent who knows his full situation, we might find much reluctance on the part of some to enter community-rated schemes whose premiums involve subsidization of those with the worst risks. If I know I have several children whom I am likely to be able to prepare for lucrative careers, then I might not want to be a risk pool with childless people. My commitment to a community-rated scheme which is not actuarily fair to me would have to be based on considerations other than prudence alone. My knowledge of particular facts about

me allows my individual interests to influence choice. Any bargains struck in the light of full knowledge then risk allowing the accidents of current age-group competition to influence unduly the arrangements governing long-term cooperative schemes. These considerations suggest that distributive principles which we need to embody in such cooperative social schemes are not likely to be derived from the prudent perspective of fully informed rational agents.

"Social" Prudence

These limits of the first strategy, and other issues in moral methodology which cannot be discussed here, incline me to the second strategy. That is, for the design of cooperative social schemes, we need a perspective which abstracts in a reasonable way from the full-blown rational consumer used by the economist, but which still permits some form of prudent reasoning about the "savings" problem for health care. At this point it is tempting to employ some version of Rawls's veil of ignorance (cf. Gibbard 1982 for an alternative approach). Thus, the prudent agents deliberating about principles to govern their cooperative scheme should know nothing of their age, family situation, health status and genetic history, socioeconomic status, or their particular conception of the good. Such a device might be defended on the grounds that the constraints are procedurally fair: They reflect the deliberators' status as "free, equal, moral agents." Of course, the agents would have to have some "thin theory of the good," like Rawls's primary social goods, or they would have nothing to be prudent about. Any justification for such a hypothetical contractor model would carry me much too far afield (Daniels 1979a, 1980). Clearly, it is not enough to suggest that the constraints on knowledge seem to be but exaggerations of the considerable uncertainty we face outside the veil in planning health and family and economic eventualities over a lifetime. But since I am not prepared to offer such a defense, I shall have to restrict myself to a suggestion. Prudent deliberators, appropriately constrained, would seek a health care and long-term-care system that protected their normal opportunity range at each stage of their lives. The notion of an age-relative opportunity range needs explanation and I explore the merits of this suggestion in the next section.

IV. Equal Opportunity and Health Care for the Elderly

Opportunity and Age

Elsewhere I have developed a general theory of distributive justice for health care (Daniels 1981a, 1981b, 1981c, 1982). On this view, health care is "special" because of its connection to the special, social good opportunity. Impairments of normal functioning mean that an individual might not enjoy the range of opportunities normal for his society. Health care needs, however, are things we need to maintain, restore, or compensate for the loss of normal species functioning. But, then, meeting health care needs is as important as guaranteeing individuals that their opportunity is within the normal range for their society. If an acceptable general theory of distributive justice requires us to guarantee fair equality of opportunity—whatever the nature of the general theory—then, a principle for the distribution of health care seems to follow. Institutions delivering health care services, both preventative and curative, should be governed by the fair equality-of-opportunity principle. It might be thought, however, that such a theory puts the elderly at a disadvantage: Are not their opportunities in the past? Is not the theory age-biased in much the same way that "earning streams" measures of the value of life are age-biased? To see that the theory is not age-biased, we must examine the notion of normal opportunity range.

The normal opportunity range for a given society is the array of "life-plans" reasonable persons in it are likely to construct for themselves. The range is thus relative to key features of the society—its stage of historical development, its level of material wealth and technological development, and even important cultural facts about it. Facts about social organization, including the conception of justice regulating its basic institutions, will, of course, determine how that total, normal range is distributed in the population. Nevertheless, that issue of distribution aside, normal species-typical functioning provides us with one clear parameter relevant to determining what share of the normal range is open to a given individual, holding constant, for the moment, his skills and talents. Impairment of normal functioning through disease (and disability) constitutes a fundamental restriction on individual

opportunity relative to that portion of the normal range his skills and talents would ordinarily have made available to him.

Of course, we also know that skills and talents can be undeveloped or misdeveloped because of social conditions (e.g., family background). So, if we are interested in having individuals enjoy a fair share of the normal opportunity range, we will want to correct (say, through education) for special disadvantages here, too. Still, restoring normal functioning has a particular and limited effect on an individual's enjoyment of the normal range. It lets him enjoy that portion of the range to which his full range of skills and talents would give him access, assuming that these, too, are not impaired by special, social disadvantages. There is no presumption here of eliminating individual differences; these act as a baseline constraint on the degree to which individuals enjoy the normal range.[5]

The notion of a normal opportunity range can be refined for its special application to our problem about distribution between age groups. Life plans, we might note, have stages that reflect important divisions in the life cycle. Without meaning to suggest a particular set of divisions as a framework, it is easy to observe that lives have phases in which different, general tasks are central: nurturing and training in childhood and youth, pursuit of career and family in adult years, and the completion of life projects in later years. Of course, what it is reasonable to include in a life plan for a stage of one's life reflects not only facts about one's own talents and skills, tastes, and preferences, but also depends in part on social policy and other important facts about the society. These qualifications already are present in the notion of normal opportunity range itself.

Prudence and Opportunity Range

The suggestion that I want to explore is that prudent design of the institutions affecting us over the different stages of our lives requires

[5] This formulation avoids criticism of my account raised by Buchanan (1983). It is important to see that the normal opportunity range abstracts from individual differences in what I call *effective opportunity*. From the perspective of an individual with a particular conception of the good, the effective opportunity range will be a subspace of the normal range (cf. Daniels 1981, 159).

reference to the notion of age-relative opportunity range. Specifically, prudent deliberation about the design of such institutions, carried out with the degree of abstraction from an individual perspective appropriate to the task, would attempt to assure individuals a fair chance at enjoyment of the normal opportunity range for each life-stage. With this refinement, the fair equality-of-opportunity account I am proposing for health care will avoid the pitfall of age-bias.

Consider now the perspective of designers of a health care system who are under an appropriate veil of ignorance. It keeps them from knowing their individual health status, conception of the good, age, income, and other important facts about themselves as individuals. At the same time, it lets them know important facts about the disease/age profile for their society, its technological level, and even that lifespan has been increasing, largely as a result of other features of social policy. One feature of their problem emerges as critical: In choosing principles for institutions that defer the use of resources, they must assume lifespan is normal. Since they cannot appeal to any very special conception of the good, which might lead them to discount the importance of their projects or plans at a certain stage of their lives, they must treat these stages as of comparable importance. Here, they are simply in compliance with Sidgwick's (1907, 381) account of rationality: Each moment of life is equally valuable and must not be discounted merely because it comes at one point in our lives rather than another.

Of course, there are standard problems facing the Sidgwickian view. Even though it disallows "pure time preferences," it does not block some "impure" reasons for discounting the value of certain moments. Nevertheless, given our problem of design from behind a veil of ignorance, some special views people might hold are not available to them. Still, there are other problems. The concept of rationality itself does not determine which moments are to count as "ours." If I refuse to plan for "my" care when "I" have advanced senility, am I being imprudent? Am I being irrational if I insist that *that* senile person (if he is one) is not really *me*, and that I do not care what happens to *him*? I ignore these worries here.

From their perspective, prudent deliberators will not know just what their situation is or what preferences or projects they might have at a given stage of their lives. Still, they do know that they will have a conception of the good and that it will determine what

is meaningful for them in their lives. But then it is especially important for them to make sure social arrangements give them a fair chance to enjoy the normal range of opportunities open to them at any stage. This protection of the range of opportunities they enjoy is doubly important because they know they may want to revise their life plans; consequently, they have a high order of interest in guaranteeing themselves the opportunity to pursue such revisions. But impairments of normal species-functioning clearly restrict the portion of the normal opportunity range open to an individual at any stage of his life. Consequently, health care services should be rationed throughout a life in a way that respects the importance of the age-relative opportunity range.

Acute Care vs. Personal Care

Let us consider two implications of this view for the design of health care systems, keeping in mind that these systems operate through time on all stages of one's life. The first implication is the suggestion that personal medical services have the same underlying rationale for their importance as various personal care and social support services for the disabled. Medical services are intended to preserve or restore normal functioning; in turn, normal functioning is important because of its impact on the individual opportunity range. But just the same rationale makes personal care and support services for the disabled elderly person important: They compensate for losses of normal functioning in ways that enhance individual opportunity.

A major criticism of the United States health care system, that it encourages premature and over-institutionalization of the elderly, should be assessed in this light. The issue becomes not just one of costs: Is institutionalization more or less cost-effective compared to home care and social support services? Rather, opportunity range for many disabled persons will be enhanced if they are helped to function normally outside institutions. They will have more opportunity to complete projects and pursue relationships of great importance to them, or even to modify the remaining stage of their life plans within a greater range of options. Often the issue is discussed in terms of the loss of dignity and self-respect that accompanies premature institutionalization or institutionalization at inappropriate levels of care. My suggestion here is that the underlying issue is the loss of opportunity range, which obviously has its effect on autonomy, dignity, and self-respect.

Viewed in this light, the British system, in which extensive home care services exist, far more respects the importance of normal opportunity range for the elderly than does our system.

Age Rationing

The second implication is more controversial, and I am less sure of it. I believe that prudence would dictate giving greater emphasis to the enhancement of individual chances for reaching a normal life span than to extending the normal life span. It might, at first, seem that such a contention runs counter to the earlier appeal to Sidgwick's principle, that it is irrational to entertain pure time preferences. But I am not urging that a given moment of life for a person older than the normal life span is worth less than a comparable moment for a younger person. About that, the prudent deliberator can make no judgment. But he must acknowledge several important considerations. Assume, for the moment, that productivity and birthrate are held constant. Then, increasing the life span—here beyond the normal range—must compel us to save resources at a greater rate in earlier stages. Where policies lead to greater longevity primarily because they reduce infant and childhood mortality rates, we are likely to have some increase in productivity, which may not necessitate greater rates of saving. But where the extension is due primarily to extending marginally the lives of elderly people, then we clearly are required to save at an increased rate. To the extent that such increased savings undermine the ability to protect normal function in younger age groups, or even in the late stages of a normal span, we face an increased likelihood of not reaching a normal life span. Prudence would thus urge us to pursue a different policy. Under the conditions imposed here on institutional design, we can abstract from what might merely be thought a matter of personal taste, whether to live a longer life with fewer resources or enjoy a better chance of living a normal life span.

Consider the rationing schemes discussed in section I. Recall that scheme A permitted no one over age 65 or 70 to get certain high-technology, high-cost services. Such rationing by age permitted the development and use of more such services for younger people. Scheme B developed fewer such services and rationed them solely by criteria

involving medical suitability and lotteries. I am suggesting that prudential considerations would incline our modified rational deliberators, choosing between such schemes, to prefer an enhanced chance of reaching a normal life span over an increased chance of living a life slightly longer than the normal span. If this conclusion is correct about where prudent considerations incline us, then my strategy of using prudence to guide justice in distributions between age groups should lead us to think scheme B is morally preferable. The whole point here is that the scheme works through time. Each of us, not just particular groups of people, will enjoy the increased chance of reaching a normal life span. And our gain in this regard is not made at the expense of another group, but at the expense of our reduced chance of living to a longer than normal life span.

The point brings to mind a rationing practice ascribed to the Aleuts: The elderly, or the enfeebled elderly, are sent off to die, sparing the rest of the community from the burden of sustaining them. From descriptions of the practice, the elderly quite willingly accept this fate, and it is fair that they should. They were the beneficiaries of comparable sacrifices by their parents and grandparents. If prudence demands such a harsh rationing scheme in the conditions the Aleuts face, then we are blocked from any suggestion that the practice is age-biased in a morally unacceptable way. Yet, this example should remind us that such rationing schemes are prudent only under certain explicit conditions. So the prudence of selecting scheme A over B in the preceding deliberation is quite sensitive to assumptions about the scarcity of resources and the way in which policies involve explicit trade-offs. The argument is not a general defense of all schemes for rationing by age.

It is worth noting one last implication of these considerations and this strategy for approaching the age-group distribution problem. Where prudent considerations do not indicate a choice between alternative schemes—and some might reject my argument leading to the selection of A over B—we may not be dealing with a consideration of justice at all. More generally, several schemes may all appear prudent, and, then, we have no basis in considerations of justice for distinguishing among them. Where there are honest differences about what is prudent, we may be dealing with cases whose resolution calls for a democratic political process, not transcendent principles of justice.

V. Equity, Errors, and the Stability of "Savings Institutions"

Equity and Uncertainty

Thus far, I have been ignoring an important question facing cooperative schemes in which saving is accomplished through a compact between birth cohorts. In such schemes, one birth cohort transfers resources for the use of earlier birth cohorts and receives similar transfers from its successors. (We support our parents and expect our children's support in return.) How can a given cohort be assured that its benefits from the scheme will be equitable when compared to the benefits enjoyed by other cohorts? If we call the ratio of benefits received to contributions made the "replacement ratio," our problem is to determine when replacement ratios are equitable (Parsons and Munro 1978).

The problem arises because we must operate such a savings scheme under conditions of considerable uncertainty. Most importantly, there is uncertainty about population growth rates, economic growth rates, and technological change, with its impact on productivity. Consequently, any such scheme must derive its stability from an underlying commitment to equity in replacement ratios enjoyed by successive birth cohorts. Errors are likely to abound and inequities will arise, but the presumption must be that these errors will be corrected. Still, this presumption in favor of correcting errors does not mean that everything is up for renegotiation all of the time. The basic institution must be stable.

Clearly, we need some theory about what equity involves here. I think this problem of equitable treatment between birth cohorts resembles the problem of a just savings rate between present and future generations, but I cannot say more about the connection here (cf. n.4). Instead, I shall rely on the point just made about the higher order interest parties have in assuring the stability of the savings institution. Stability requires a belief in equity. If one cohort seeks terms too much in its favor, say when it is young, it will very likely pay the price when it is old; similarly, if it seeks too much when it is old, it will risk rebellion by the young. My guess is that there is a tendency to view equity as requiring approximate equality in replacement ratios. In any case, I shall make such an assumption, primarily for the sake of illustrating a slightly different point.

Suppose, then, that mature savings schemes, those in which ben-

eficiaries have been long-time contributors, should treat different birth cohorts equally. They should aim for equal replacement ratios. In the "steady state" condition, where there is no economic growth and no population increase, the assumption is unproblematic. In favorable conditions, of positive economic growth and increasing population, we can, in fact, do better in the following sense: Benefits can steadily increase, even if rates of contribution do not. Of course, equity considerations between cohorts might incline us to temper this "chain letter" effect: If we could project the economic and demographic trends, we might raise the replacement ratios of earlier cohorts somewhat to offset the anticipated increasing rates of later cohorts. Unfortunately, in our social security and health care contexts, we now face the opposite conditions: declining birth rates and poor economic growth. What this means in the Social Security system, for example, is that the current 3:1 ratio of contributors to beneficiaries will decline to about 2:1 by 2030 (in the immature system of the 1950s, ratios were even more favorable). To maintain current benefit levels, contributors have to be taxed at tremendously high rates. (The same point applies to health care savings schemes.) What is worse, much of our recent planning, including the major benefit increases of 1972, seemed to ignore these shifts. To have planned for equity in replacement ratios, many critics argue, would have required: 1) taxing earlier generations at a yet higher rate than they were taxed; 2) stunning increases in real wages through rapid economic growth; 3) reducing benefits substantially in the interim; or 4) some combination of these steps.

One problem is that the presumption in favor of equitable treatment between cohorts encounters strong resistance in the political arena. Some cohorts are in a better position to protect their interests than others, undermining long-term stability of the scheme. A second problem is that not everyone believes or understands the problem, and there is often reason to think some factors are exaggerated, perhaps for ideological reasons. Thus, many people point with alarm to the shifting ratios of contributors to beneficiaries. But there is a countervailing point: The total ratio of employed to nonemployed, lumping retirees together with children, is not changing in such an alarming way. The ratio of total nonlabor to labor is higher in 1975 than for any year through 2040 (Schultz 1980, 11). The implication is that the smaller number of children will require fewer resources, which can then be diverted for use by the then elderly baby-boom cohort. What

follows, then, is that we must not look too much at one distributive institution in isolation from others.

Nevertheless, the general point remains. We operate an income or savings scheme in a nonideal context. It will always encounter various sorts of interstitial equity considerations which are generated by both great uncertainty and political expediency (Barry 1965, chap. 9). A good example is the tremendous replacement-ratio advantage offered the early entrants into our Social Security system; attempting to lower that ratio might have undermined political support for the Social Security system as a whole. Similarly, in the United States, no fund was ever generated which was significant enough to cushion the effects of our current decline in real wages and declining population growth rate. Politicians were afraid to raise tax rates without pairing the increases with benefit increases. More interesting details of this history are available and constitute an important case study of the contrast between ideal and nonideal contexts (cf. Derthick 1979).

It is interesting to note that health care savings schemes face comparable—or even more serious—problems of birth cohort equity. First, as in the case of income support schemes, there will be a bias in favor of early entrants. Such a bias is hard to avoid in immature schemes. But there also is an opposite bias in the case of health care. Consider a scheme in which some form of age rationing of new technology is involved. Our scheme A will do as an example. An elderly person might complain about A by saying it is not really fair to his cohort: The cohort never had the benefit of increasing the chances of reaching a normal life span because the technology (say dialysis) now being denied it was also not available in its youth.

Two points might be made in response to this complaint. First, it might be argued that each birth cohort is treated equally in the following way. At some point in life, each cohort will be denied the best available life-extending technologies, but at all other points in life it will have a better chance of receiving them. To be sure, the particular technology (dialysis) denied may not be the very one it had a better chance of receiving, but there is a fairness in the exchange. Still, if technology improves very rapidly, then the bargain is not quite as favorable from a prudent perspective as it might have seemed when we ignored the fact or rate of technological advance. A second point is more general: Some such changes, e.g., in technology, are at least as difficult to project as the other factors which lead to

error (replacement ratio differences) in saving schemes. Indeed, it seems, in general, to be the case that we might be even more prone to error in the health care setting than in the income-support setting. In such a context, given the overriding importance of stability in such schemes, considerable tolerance for error must obtain.

VI. Some Qualifications

Limits on Argument

It is easy to misconstrue, at least to misapply, my argument. It does not, in general, sanction rationing by age. Such justification is possible only under very special circumstances. First, it is crucial that the appeal to age criteria is part of the design of a basic institution that distributes resources over the lifetime of the individuals it affects. Nothing in the argument offered here justifies piecemeal use of age criteria in various individual or group settings—e.g., by some hospitals or physicians, or in any way that is not part of an overall prudent allocation. Second, the argument should not be taken as a hasty endorsement of age rationing as a convenient "cost-constraining" device in the context of current debates. Not only is such an application not likely to be part of the design of our basic health care institutions, construed as a savings scheme, but many of the assumptions about resource scarcity which might make rationing by age prudent in some circumstances are controversial in the context of this public policy debate. Finally, it is important to see that my argument is part of an ideal theory of justice, in which we can assume general compliance with principles of justice which govern other aspects of our basic social institutions. The argument does not readily or easily extend to nonideal contexts, in which no such compliance with general principles of justice obtains. Thus, it would be wrong to say that my argument actually justifies the British system of rationing dialysis by age (assuming that that is the practice). At most, my argument shows that such rationing *can* under some circumstances be part of a just institution, that it is not always morally objectionable in the way that sex or race rationing would be. The argument shows the conditions that would have to obtain for such rationing to be just.

Ideal and Nonideal Contexts

The point about ideal and nonideal contexts needs some explanation, for it underlies much of my reticence here. It is important to see that many of the problems facing large numbers of the elderly in our society are consequences not of age-bias but of other inequalities—and, I would argue, injustices. The worst-off among the elderly are usually the same people who were worst-off in earlier stages of their lives. Problems with social and individual savings schemes may exacerbate their plight, but their ultimate situation is largely determined by their earlier position in society. This is not, of course, to say that they are getting what they deserve. It is to raise the more basic question about the justice of the underlying distributive institutions. In the context of such injustice, it is merely blaming the victim to talk about the inadequacy or even the imprudence of their savings. No one could reasonably be expected to save prudently for old age from such inadequate income and wealth shares in their working years. Of course, we can rectify or adjust for underlying inequities by income and health care support in the later years, which we to some extent do. But this adjustment should not primarily be seen as an issue of justice between age groups; it is really a more basic issue of distributive justice which forces the correction.

Nevertheless, I have been claiming that there is a distinct problem of distributive justice between age groups. The residual problem is to select principles of distributive justice that will govern the basic institutions responsible for distributing social goods through the various stages of life. My proposal has been that some form of prudent reasoning should guide the design of such institutions. From the perspective of such institutions, goods are distributed through the stages of a life, not between different persons in distinct age groups. In the case of health care institutions, justice requires we allocate health care in a manner that assures individuals a fair chance at enjoying the normal opportunity range, and prudence suggests that it is equally important to protect the individual opportunity range for each stage of life. Under certain assumptions, prudence would urge some forms of rationing by age. Similarly, prudence might suggest that some forms of nonmedical services which meet the health care needs of the elderly are more important than certain medical services, because they better protect the normal opportunity range for

that stage of life. But suggesting that prudence is our guide to the design of savings institutions does not, of course, mean that these matters of design are not matters of justice. Here, prudence guides justice; it does not prevent us from talking about it.

In proposing that we use prudent considerations to determine the justice of distributions between age groups, I take for granted a background involving other just institutions. It is in this sense that I have been concerned with a problem in what is known as ideal moral theory; we are looking at principles and institutions operating in a society which is in general just. Remarks about the permissibility of rationing by age must thus be taken in this context. If the basic institutions of a given society do not comply with acceptable principles of distributive justice, then rationing by age could make things even worse. Indeed, prudent considerations that might endorse rationing by age depend on what sort of resource scarcity exists. Moreover, it is important to know what the source of the scarcity is. If the scarcity is the result of unjust arrangements operating elsewhere in the system, then the argument of prudence may well be undermined.

My worries here are part of a more general problem. In another context (Daniels 1981d), I have argued that the moral philosopher considering issues of public policy must take into account both the *framework* for the problem and the *context of compliance*. A framework is determined by how much of the basic fundamental political, social, and economic institutions we take to be fixed and how much we allow to be revised in the social system under question. The more major changes of fundamental institutions we allow, the more basic the framework. The context of compliance is the degree to which the problem arises in a society which complies with acceptable principles of justice for its basic institutions. Ideal theory is full-compliance theory.

Philosophers (myself included) have generally concentrated on basic frameworks and have for the most part concerned themselves with ideal theory. Yet public policy makers operate in less basic frameworks and, I believe, in contexts far from ideal. Too little philosophical attention has been paid to the problem of making points developed for basic frameworks and ideal theory relevant to the public policy maker. Philosophical vision is fine, but the philosopher must focus his vision on the problem raised by the policy maker. Unfortunately, the myopic bureaucrat, whose vision has adapted to ensure his survival

in nonbasic frameworks, may not see any relevance in philosophical vision. What is at once a philosophical problem, of connecting ideal and nonideal contexts, is also a political problem: The philosopher must not let himself become myopic as the price of seeing things in the relevant light.

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Acknowledgments: This paper is a revised version of my paper "Am I My Parents' Keeper?" which was published in *Midwest Studies in Philosophy* 8:517–40 in 1982, and which also appeared in *Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services.* Vol. 2: Appendices, Sociocultural and Philosophical Studies, a report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Washington, March 1983. Research for the original paper was funded by the National Center for Health Services Research, Grant Number HS 03097, OASH. The revisions in this version, mainly in the opening and concluding sections, were supported by the Retirement Research Foundation and the National Endowment for the Humanities. I am indebted to Mary Anne Bailey, Hugo Bedau, Christine Bishop, Dan Brock, Allen Buchanan, Leslie Burkholder, Joshua Cohen, Daniel Dennett, David Gauthier, Allan Gibbard, and Daniel Wikler for helpful discussion of the original version.

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