

POVERTY, AGE DISCRIMINATION, AND HEALTH CARE

Leslie Pickering Francis

In Euripides' play *Alcestis*, Alcestis' middle-aged husband, Admetus, is told by the gods that it is his turn to die next. Admetus bargains a reprieve, promising in exchange to find another soul to take his place. His friends all turn him down. So do his father and mother. Admetus rebukes his father for the refusal. But his father replies that life is precious to him, too: "You are glad to see the light; do you suppose your father isn't?" (Hadas, 1960: 19). His father does not waver in the belief that he has no obligation to give up his life for Admetus, even though Alcestis, Admetus' wife and mother of their small children, volunteers to take Admetus' place. Alcestis, too, believes that "nothing is so precious as life." She is not, however, generous in her evaluation of her father-in-law's refusal to take Admetus' place. She thinks it appropriate for Admetus' parents, who had "come to a time of life fitting for death," to make the sacrifice (Hadas, 1960: 9–10).

Euripides' moral drama has a number of philosophically important features. It concerns a basic good, perhaps the most basic good of all: life itself. It constructs a distribution problem in a situation of scarcity: not all can live. The problem involves reallocation rather than the distribution of an initially unattached good, for Admetus is seeking to persuade someone to die in his place. The characters place an extremely high value on their own continued existence; only Alcestis is willing to make the final altruistic sacrifice. They disagree, however, about the objective value to be assigned each other's continued existence. This disagreement is connected to their views about the moral significance of age. Admetus and Alcestis think that it is appropriate—indeed, obligatory—for Admetus' parents to offer to die in his place. His parents believe that it is not.

The moral significance of age, primarily advancing age, is the focus of this paper. In the first section, I outline the contemporary relevance of the *Alcestis* theme for health care allocation and financing. In the second section, I explore whether age-related differences in subjective valuations of the goods to be distributed can support differential treatment of the elderly. If Admetus' parents had found life less sweet than the younger Admetus, would this matter morally? In the third section, I consider whether there are age-based differences in the objective value of goods that can justify age-based differences in treatment. Have Admetus' parents come to the time at which

their lives are less valuable and so weigh less heavily as we frame social policy? In the fourth section, I take up Norman Daniels' suggestion that age and health care policy should not be viewed from a single point in time but as a problem of rational, prudential allocation across the entire life span. In the final section, I look at differential treatment of the aged as a consequence of the egalitarian view that it is preferable, if possible, to distribute goods more widely rather than to concentrate them in the hands of a few. Until this final section, I hold aside the complication that the Alcestis story involves reallocation rather than the distribution of unattached goods.

CURRENT VARIATIONS ON THE ALCESTIS THEME

Present social policy in a number of areas expresses apparent ambivalence about the moral significance of age, both youth and old age. Health care distribution is a prime example.¹ Discrimination against the aged is prohibited and special programs for the aged are in force, yet there is renewed pressure for cost savings in these programs that may result in forms of rationing by age.

The Age Discrimination Act of 1975 prohibits age discrimination in any federally supported program. It allows federal programs, however, to be targeted to particular age groups, such as the young or the elderly. It also permits age to be taken into account if it is a factor necessary to the normal achievement of a program's statutory objectives (42 U.S.C., sections 6102-03). Thus Medicare can be authorized only for those over age 65. By contrast, federally-supported health care programs that are aimed at the general population, like Medicaid, cannot simply deny people benefits because they are old. General programs may, however, limit services by age in pursuit of statutory objectives. For example, therapy paid for by Medicaid might be limited by age if it is less likely to succeed in older patients.

The share of federal budgetary resources devoted to the elderly has nearly doubled since 1960. Almost 28 percent of federal spending for 1985 will benefit the 11 percent of Americans age 65 and over (Senate Committee on Aging, 1984c: iii). Some of this spending is in programs aimed at poor Americans generally, such as food stamps, public housing, and legal services. But the bulk of the spending is in two programs targeted specifically to the elderly—Social Security and Medicare—the two largest federal domestic spending programs. It is estimated that in 1985, 55 percent of federal spending on the elderly will go for Social Security (\$140.1 billion); 28 percent will go for Medicare (\$64.9 billion) and Medicaid (\$7.5 billion) combined (Senate Committee on Aging, 1984c: 7).

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The next two decades may bring a 70 percent increase in the population aged 75 and above (Aaron and Schwartz, 1984: 113). Although increases in federal spending on retirement income programs have slowed, increases in federal spending on health care have not. Federal spending on health care for the elderly is projected to reach 6 percent of the gross national product by 2030 (Senate Committee on Aging, 1984c: 20). The hospital insurance portion of Medicare is financed from the Social Security payroll tax and cannot under current law be supplemented from general revenues. The cost of this program was 2.97 percent of the Social Security wage base in 1982 and is expected to nearly quadruple by the year 2035 (Aaron and Schwartz, 1984: 113). Despite the 1983 bailout of Social Security, at current levels of financing the hospital insurance trust fund is expected to be depleted around the end of this decade and to run annual deficits of \$60 billion by 1995 (House Subcommittee on Health, 1984: 1-2).

Even more serious financing difficulties may occur in the supplementary medical insurance program of Medicare, which pays for out-of-hospital care. This program has the highest rate of expenditure increase of any domestic spending program; projected expenditures of \$25 billion in 1985 will represent a 16.1 percent increase over 1984 levels (Senate Committee on Aging, 1984b: 1). The program is financed in part by patient premiums and in part from general revenues. Unless premiums are increased, 5.7 percent of general revenues will be needed for the program by 1988 (House Subcommittee on Health, 1984: 6).

Despite these increases, health care costs have consumed a growing proportion of the income of older Americans. Today, nearly half of the households headed by someone 65 or older have incomes of less than \$10,000 per annum (*Salt Lake Tribune*, Jan. 13, 1985). Yet by 1981, the percentage of average per capita income paid out of pocket by the elderly for health care was 19.9 percent, nearly the pre-Medicare level of 20.4 percent (Senate Committee on Aging, 1984c: 10). These expenditures went mostly for out-of-hospital physician services under the supplementary insurance program. In some states, physicians refused to accept Medicare as payment in full on over 90 percent of claims, with remaining costs shifted to Medicare patients (Senate Committee on Aging, 1984b: 32).

Some of the cost increases may be attributed to demographic shifts. Some may result from unnecessary duplication or inflation of medical services. By far the largest portion, however, is due to advances in medical care itself. Estimates are that 4 percent per annum of the 12.4 percent per annum growth in hospital insurance spending results from increased intensity of

service. Services like hip replacements are performed more often, and conditions like heart disease are treated with a growing panoply of techniques (House Subcommittee on Health, 1984: 2-5). Over half of the increase in the supplementary medical insurance program is attributed to growth in the intensity of services, especially from specialists (House Subcommittee on Health, 1984: 6).

Proposals for reform include cutting costs of services, reducing the number of covered services, or shifting responsibility to beneficiaries (House Subcommittee on Health, 1984). All of these have some potential for either direct or indirect rationing of medical care to the aged. Proposed changes in the method of reimbursing physicians on a fee-for-service basis, for example, might decrease the mix of physicians accepting Medicare patients or assignment of Medicare claims (Senate Committee on Aging, 1984b: 26-29, 35). Increased cost sharing by patients, depending on its structure, might discourage use of services (House Subcommittee on Health, 1984: 30-48).

To the extent that the financing crisis results from increased intensity of services, limits on coverage, particularly coverage of new technologies, may seem an increasingly attractive means to contain costs (Aaron and Schwartz, 1984: 119; House Subcommittee on Health, 1984: 129-48). Aaron and Schwartz (1984: 124) suggest that when choices get hard, the most likely care to be eliminated will be aggressive therapy for the terminally ill, many of whom are likely to be old. Next likely are slower introduction of new therapy and less widespread use of expensive techniques like the artificial heart, especially if they require large capital expenditures or trained personnel (1984: 125-28).

The British do appear to ration care in these ways. Fewer resources are allocated in Britain to the treatment of terminal illness in intensive care units (Aaron and Schwartz, 1984: 96-97). Dialysis rates in Britain are approximately one-quarter of rates in the United States (Aaron and Schwartz, 1984: 33). Despite the professed rationale of medical efficacy, much of the variance appears to be explained by the age of the patient. In the words of one British consultant, patients over the age of 55 are "a bit crumbly" and not well suited for dialysis (Aaron and Schwartz, 1984: 35).

Although older patients on dialysis do experience higher death rates than younger patients, one may be pardoned the suspicion that this policy is in part supported by the feeling that age itself matters morally. It is important to see whether age does matter and, if so, on what moral grounds.²

AGE AND THE SUBJECTIVE VALUE OF LIFE

One argument for the moral relevance of age is suggested by the comment of Admetus' father that life is as sweet to him as it is to Admetus. Suppose that his father is highly unusual and older people value life less than younger people. Perhaps the difference is in life as an instrumental value, as the pleasures life brings shrink or give way to pain. Or perhaps life just comes to seem less important.

A utilitarian or indeed anyone concerned to maximize the efficient use of scarce resources might draw a chilling but clear implication from this difference. Goods are to be assigned where they will create the most subjective value. If this means that beef-lovers get steak, music-lovers get flutes, and those with the most zest for life get first crack at the means of life, so be it. Efficiency appears to support giving those who value life the most priority in the distribution of life-saving resources. If these are the young, then the young should have priority in the distribution of medical care.

The apparent efficiency of these assignments could be outweighed by other consequences – what might be called moral externalities. The effects of a distribution on our respect for persons, for example, might easily outweigh the benefits of the distribution to those actually receiving goods. But an argument from externalities is not the strongest way to criticize these provisional assignments. It leaves their initial appeal untouched. In this section, therefore, I explore direct reasons for concluding that the moral relevance of age cannot be established from differences in subjective valuations.

In the first place, in the case so far there is no link to age. To bring in age, it must be shown that there are age-related differences in the values people attach to life or goods to which life is instrumental. If the differences are uniform, age could substitute for less easily measured subjective valuations. If the differences are pronounced and pervasive, but not uniform, the argument for age as a stand-in must rest on administrative convenience. Administrative convenience is a persuasive consideration when the goods at stake are such that we are willing to risk a less than optimal allocation in order to save administrative costs. Jobs, perhaps, fit this characterization; but life does not.

Moreover, it seems unlikely that there are such pervasive differences between the old and the young in the value they attach to life. What data there are suggest that those who have not experienced discomforts or handicaps

are likely to give lower hypothetical evaluations of an afflicted life, than those who have had such experiences (Avorn, 1984). The young may think less of life in old age than their elders do. Thus Admetus and his father: Admetus expects his father to value life less than his father actually does.

Even if we found widespread differences in the subjective evaluations of life given by old and young, we could not take the data at face value. If the elderly are poor, ignored, and without supportive services (such as home health care), it would not be surprising for them to report valuing life less than those whose comfort rests on home mortgage tax deductions or publicly supported schools. But to use these reports as a moral reason for the priority of the young would simply compound injustice.

Finally, there is a general moral concern about the use of subjective preferences in allocation (Scanlon, 1975). Suppose we must allocate a scarce life-sustaining good to one of two individuals. We discover that one wants the good more and that this difference does not appear to be the result of prior injustice, or even of remediable features of the person's situation in life. To ignore the difference in intensity is to risk wasting a good on someone who will not make use of it. On the other hand, to let this difference in desire make an allocative difference is to let those with more intense preferences have a better chance of enjoying a good and to treat more moderate individuals with questionable fairness. The impact of intensity may seem more problematic as more basic goods are involved, such as life or the means of life. Health care for the elderly achieves many goods—comfort, mobility, the enjoyment of activities including continued fruitful work—intertwined with the preservation of the underlying good of life itself.

THE OBJECTIVE VALUE OF LIFE IN OLD AGE

A second argument for the relevance of age is suggested by Alcestis' assertion that her father-in-law's life is less worthwhile than the life of a younger person. There are several ways in which this claim might be understood as a claim about objective value. It might be a claim about instrumental value: that the old contribute less, to themselves and to others. Or it might be a claim about the intrinsic value of life in old age, that it is qualitatively inferior.

The claim about instrumental value founders on the facts, if the old contribute in the time-honored ways of senior statesmen. But if it does not, we are left with a chilling triage. As practiced in the allocation of dialysis, this triage came under extensive criticism (Winslow, 1982), to which I shall

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not add here. The triage, however, is not based on age. The connection to age is only contingent, and the triage would likewise place lesser priority on health care for those at any age who are judged less valuable to society.

Much of the difficulty with the claim that life at an old age is less intrinsically valuable than life at an earlier stage lies in understanding it as an independent claim. On the one hand, it may be nothing other than the assertion about subjective valuations discussed in the preceding section. On the other hand, it may collapse into the contention to be argued for, that age matters morally. At worst, the claim is rank prejudice. At best, it is at odds with other claims we make about intrinsic value. For example, an amphora becomes more valuable with age, even though it has not qualitatively changed in ways unrelated to age. These concerns seem sufficient to place the burden of proof on defenders of the view that age matters morally because the lives of the aged are less intrinsically valuable than the lives of the young.

DANIELS AND PRUDENCE

In a series of recent papers, Norman Daniels has proposed approaching aging and health care from the standpoint of prudential reasoning. In Daniels' view, age rationing of medical care can be justified on prudential grounds.

Daniels uses a Rawlsian framework.³ He imagines choosers behind the veil of ignorance, deprived of knowledge of their peculiarities: their race, sex, talents, genetic history, health status, socioeconomic position, and individual conceptions of the good (Daniels, 1983: 507). In the Rawlsian scheme, choice occurs in stages, with earlier choices constraining later ones. Choosers at each stage know progressively more about their society but remain in ignorance of themselves. A health care system is to be chosen at the stage when basic social institutions are selected. At this stage in the sequence, choosers know basic facts about their society, such as its resources, level of development, and typical styles of life. They are constrained by prior choices of the principles of justice and their society's constitutional design.

The significance of health care, Daniels argues, is to open and preserve opportunities. Choosers, not knowing their peculiar health needs, will be unable to tailor a health care system to their own best interests. They will know, however, the array of life plans typically constructed by people in their society, at all ages. Daniels calls these the "normal opportunity ranges." He emphasizes that the ranges vary at different stages in the life cycle (Daniels,

1983: 508; Daniels, 1981). For example, middle-aged individuals are likely to be raising children and older people to be concentrating on bringing plans to fruition. The choosers, Daniels concludes, will construct a health care system to give each a fair share of the normal opportunity range at each stage of life (Daniels, 1983: 510).

In our society, if we cannot afford all beneficial care, this system will not provide the same health care at all points in the life cycle. Impairments of typical species functions, from mobility to procreation, are what most curtail individuals' abilities to enjoy the normal opportunity range. Likely impairments, however, vary with age. For example, nursing support and home housekeeping services have a major impact on the opportunities of the elderly. The choosers would provide them. Intensive care technology, in contrast, may avoid premature death for the young but prolong the life of the old only briefly. It would be rationed by age, if resources are insufficient to provide it for everyone (Daniels, 1984: 23–25).

Daniels is not troubled by these conclusions. To argue that they fit our considered moral judgments, he begins with a truism. Rich or poor, black or white, talented or handicapped—none can avoid the passage of time. As a distributive consideration, Daniels infers, age is unlike sex and race, which do not affect us all equally. Age distribution takes place within a life, rather than across lives. It is not “age-ist,” Daniels contends, to allocate different benefits at different points in life. Nor is it “age-ist” to impose costs disproportionately on younger workers, if these workers have been higher cost users as children and will eventually return to the higher use categories themselves (Daniels, 1983: 495). Daniels would, however, regard a scheme as “age-ist” if it allowed some groups to gain at the expense of others (Daniels, 1983: 513).

Unfortunately, allocation across the life cycle is more like the problem of racial or sexual discrimination than Daniels admits. Time passes for us all, but we are not all lucky enough to age. Congenital and genetic conditions are ours from birth; we do not grow into them. Insofar as we become able to identify a genetic component in more and more illnesses—from Huntington's chorea to hypertension to cancer of the colon—allocation across the life cycle comes to resemble the problem of allocation across lives. Diseases caused by differentially distributed environmental and cultural factors, such as asbestos exposure or diets low in fiber, likewise have very differential impact on people. Indeed, Daniels' picture only works for conditions that we are all at risk for developing over a lifetime, like chicken pox or pneumonia. Even here, the risks are unlikely to be equal; for example, patients with

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cystic fibrosis, a genetically transmitted disease, are at far greater risk for pneumonia than members of the general population.

The choosers thus are not engaged in distributing resources across their own futures. The allocation they choose cannot be defended on the ground that age is fundamentally unlike race or sex as a factor in distributive justice. Instead, the allocation is prudential for those who, with health care, will enjoy a normal life span. We must therefore look to the Rawlsian scheme itself to justify age-related allocation. As Daniels reconstructs the scheme, it yields age-related allocations but in a morally unacceptable manner. The difficulty is that age bias is built into the central notion of a normal opportunity range.

In Daniels' view, the notion of a normal opportunity range is the benchmark that enables choosers to design a health care system. Without it, choosers would need another benchmark against which to decide what kinds of health care should be provided. But alternatives do not seem promising. Knowledge of their own needs would introduce individual bias. Designing health care to ameliorate the situation of the worst-off individual risks commitment of unlimited resources for little gain.

As Daniels characterizes it, the age-related normal opportunity range for a given society – the array of life plans that reasonable persons in that society are likely to construct for themselves at a given stage of life – is relative to wealth and cultural values (Rawls [1971: 199] also includes knowledge of cultural practices when social institutions are chosen). Now, we can imagine a culture (call it “Lamms-ville”) in which old people believe it is in their interests and is their responsibility to die. They make no plans, except for graceful deaths and inexpensive funerals. It seems perverse to refer to these plans as the normal opportunity range for the elderly in Lamms-ville. Yet in Daniels' account, they would delineate the range.

A possible solution is to use the veil of ignorance to block out knowledge of such cultural practices. The choice of a health plan takes place at the stage of selecting institutions, when individuals know facts about their society such as average life spans. Although cultural practices and life spans are intertwined, one could try to construct an account of opportunity ranges that is independent of culture such as that found in Lamms-ville.

But what would the account look like? Age-related differences in opportunity ranges could not reflect differences in the patterns of life plans that are the result of what is generally done in the society. Thus they could not reflect differences in social practices like a standard retirement age. Nor, although the choosers do know the general economic constraints faced by their

society, could the opportunity ranges reflect economic allocations such as the generally more limited incomes of older people. Otherwise, the design of the health care system would be constrained by the very economic choices that are at issue. The normal opportunity range could still reflect differences in physical capacity, to the extent that these are not induced by social choices. For example, they could include the observation that childbearing for women ceases to become possible after menopause. But these are the only differences they could reflect.

A health care system designed on this basis would certainly differentiate care by age relative to physical changes over the life cycle. Just as it would provide pediatric care for the young, it would provide geriatric care to the elderly. But this is only to provide care based on medical appropriateness, not to ration by age. Nor are there grounds for thinking that the choosers would age ration in any further sense, for the choosers have no knowledge of which of the panoply of physically available plans they will want to pursue at any stage of life.

Daniels does not, therefore, provide an argument from prudence to the relevance of age. This is not to reject his conclusions: it seems entirely sensible to improve home health services to the elderly, as well as to others who need them, and to limit marginally beneficial intensive care. But these conclusions are a matter of the optimal use of resources, not of age.

EGALITARIANISM AND AGE

The final argument for the relevance of age that I shall discuss in this paper is a kind of strict egalitarianism. Suppose we believe that, other considerations aside, the fact that one person has enjoyed more of a good than a second is a moral reason for giving the second preference when the next distribution occurs. Those who are older have, by definition, had more of the good of being alive than those who are younger. Health care may be a crucial means of life. Then the fact that someone is expected to have a shortened life span would be a moral reason for giving him priority in the distribution of life-sustaining health care over someone who has already lived four score and ten⁴ (Menzel, 1983: 188; Veatch, 1979: 211). This is the most straightforward argument for an age cutoff in health care: age means having had more of the good of life. The serious questions about the argument rest in whether the egalitarianism it represents is either a very clear or a very compelling moral concern.

First, clarity. Is the egalitarianism on which the argument rests equal

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distribution of life, of the means of life, or of the package of goods experienced during life, and why? Compare two candidates for life-saving therapy, one of whom is younger but who has consumed a much greater share of social resources for health care. Compare these two with a third who is younger still but already has had a far more fulfilling life.

These case-by-case comparisons are a morass. But the egalitarian can avoid them. Part of the critical thrust of the examples just given is that when we consider the distribution of health care in the United States today, we are designing social policy for a situation of partial compliance. Unjust distributions of other goods, or even of prior access to health care, may already have shaped the lives of those in need of care. For example, someone less well off may have had to make greater demands on the health care system earlier in life.⁵ Someone else may have lived a more fulfilling life because he began with more than his fair share of social resources. Even leaving aside differences in what Rawls (1971) calls the natural lottery, if this background of social injustice is serious enough, a move towards egalitarianism only compounds the injustice done to truncated lives.

Background injustice, however, is not the only factor involved in the appeal of individualized comparisons. Ill-health, job satisfaction, family life—all are at least somewhat a matter of luck. One way to clarify the egalitarian intuition is to focus it on the distribution of a few basic goods, such as life and the means of life. This clarification ignores all these other underlying individualized differences.

But the price of clarification may be that egalitarianism seems less compelling, because of the focus on basic goods. Egalitarianism may also not seem very compelling in light of other moral considerations. Efficiency matters. So may background features of the situation such as whether any promises have been made about enjoyment of the good or whether the distribution is a reallocation affecting entrenched expectations. The suggestion is just that egalitarianism is an argument for taking age into account, not that it should be morally determinative.

I do not find these difficulties with egalitarianism overwhelming. There are those who will find them so. Nonetheless, it is important to know that the best argument for age rationing in the distribution of health care, ironically, is an egalitarianism many will find unacceptable.

University of Utah

NOTES

1. Employment policy is another example. In 1978, the statutory ceiling of protection from mandatory retirement was raised to age 70. This passage of the Age Discrimination in Employment Act Amendments of 1978, Pub. L. 95-256, 92 Stat. 189, has spawned extensive debate over age as a bona fide occupational qualification. See, for example, Note, "Age Discrimination in Retirement: In Search of an Alternative," 1984. The protection of seniority is a major limit on other federal antidiscrimination policy, given augmented significance in the Supreme Court's holding last term that routine application of a seniority system that results in layoffs of more recently hired minority workers is permissible, absent proof of discriminatory intent. See *Firefighters Local Union No. 1784 v. Stotts*, 52 U.S.L.W. 4767 (1984). Although seniority is not necessarily correlated with age, the *Memphis Firefighters* decision seems sure to generate renewed scrutiny of the role of older workers.

2. This paper only considers direct arguments for the significance of age. There are also arguments that age is indirectly relevant to health care distribution. For example, the Stanford heart transplant program was initially limited to younger patients, because at the time transplants were unlikely to succeed in older patients. As medical skill advances, however, the medical justification for the age cutoff erodes, and age itself becomes more prominent as a justifying factor.

The paper is also limited to arguments for age as a cutoff. There may be reasons why we should provide more medical care to the elderly than to those at any other stage of life—for example, that the elderly deserve our extra concern because of the contributions they have made to society over their lifetimes. I do not discuss these arguments here.

3. Prudential reasoning *ex ante*, with full knowledge of lifetime health needs, will not yield consensus on age rationing. Those who know they will need otherwise unavailable care at younger ages will find age rationing in their interests. But those who know they will be healthy when young will prefer to defer resources to later stages. If the choice of health care is made *ex post*, choosers can be expected to demand health care when they find themselves in need of it. Daniels' use of Rawls is thus the most promising defense of age rationing on prudential grounds.

4. Similarly, other considerations aside, the fact that someone has worked at a valued job for a longer period of time would be a reason for letting someone else have first crack at the next assignment. This kind of egalitarianism cuts for mandatory retirement and against seniority. It has been used by Michael Perry (1981) in defense of the claim that mandatory retirement does not violate equal protection, although Perry attempts to explain the claim as a consequence of the moral status of the older person.

5. Employment policy is full of similar cases. For example, a woman approaching retirement age may have had few years to enjoy a job, because discrimination discouraged her earlier entry into the labor market.

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