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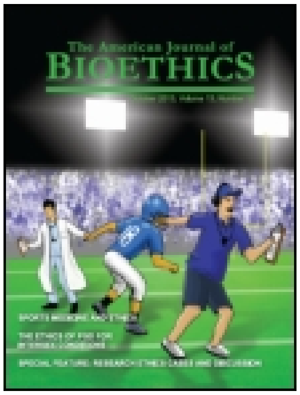

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Nancy S. Jecker [a]
[a] University of Washington School of Medicine

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Target Article

Justice Between Age Groups: An Objection to the Prudential Lifespan Approach

Nancy S. Jecker, University of Washington School of Medicine

Societal aging raises challenging ethical questions regarding the just distribution of health care between young and old. This article considers a proposal for age-based rationing of health care, which is based on the prudential life span account of justice between age groups. While important objections have been raised against the prudential life span account, it continues to dominate scholarly debates. This article introduces a new objection, one that develops out of the well-established disability critique of social contract theories. I show the implications of this critique for the prudential life span account and for the special case of age-group justice. The result is that age-based rationing based on the prudential life span approach is not supported, and that the prudential life span approach itself is not the best way to think about allocating health care between age groups. I propose an alternative approach that avoids the disability objection, and consider its implications for specific proposals for age-based rationing of health care.

Keywords: aging, right to health care, moral theory, disability, chronic conditions, rehabilitation, health policy, philosophy

A society is said to age when its number of older members increases relative to its number of younger members. The societies in most of the world's industrialized nations have been aging since at least 1800. In 1800 the demographic makeup of developed countries was similar to that of many Third World countries in the early 1990s, with roughly half the population under the age of 16 and very few people living beyond age 60. Since that time, increases in life expectancy, combined with declines in fertility rates, have dramatically increased the proportion of older persons relative to younger persons in developed nations.

The aging of societies carries important implications for health care. Societal aging will increase health care expenditures simply because persons over the age of 65 years consume far more health care than other age groups do. For example, in the United States persons 65 and over account for roughly thirteen percent of the population, but utilize 36% of the country's total personal health care expenditures exclusive of research costs. To put this in perspective, consider the fact that while the average health care expense for elderly people is $11,089 per year, it is only $3,352 per year for those ages 19 to 64 (U.S. Department of Health and Human Services, Agency for Healthcare Research 2006).

The disproportionate cost of caring for a nation's elderly makes the elderly an obvious target for health care rationing. Yet overt efforts to limit health care to the elderly have generally been met with resistance. Major international organizations, such as the European Union (2007, Article 21), the World Health Organization (2002), and the United Nations (1948, Preamble), have rejected any form of age-based discrimination, and stress the equal rights of elderly people to access health care. In the United States, the Patient Protection and Affordable Care Act restricts any reduction in services or increase in fees to beneficiaries of Medicare, the federal program serving the nation's elderly and disabled. Despite such resistance, public monies to pay for health care are limited. As the Medicare Trustees Report of 2012 makes clear, Medicare expenditures have exceeded income annually since 2008, and are projected to continue doing so until the fund becomes exhausted in 2024 (Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds 2012). It also remains to be seen whether certain provisions of the Affordable Care Act will limit access for seniors. For example, some express concern that efforts to reduce the growth in Medicare spending by means of care coordination and disease management programs designed to reduce avoidable hospitalizations will limit access to care for frail elderly with multiple chronic conditions who require hospitalization (Konetzka, Karon, and Potter 2012). Implicit rationing of care to the elderly may occur even when age-based rationing is not part of an explicit policy or plan.

To address the high cost of caring for the elderly, some bioethicists defend age-based rationing of health care. One of the most influential arguments supporting age-based rationing is advanced by Daniels, who urges us to think about the problem of justice between the young and old from a prudential, first-person perspective. Daniels's Prudential

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Address correspondence to Nancy S. Jecker, PhD, University of Washington, School of Medicine, Department of Bioethics & Humanities, Box 357120, Seattle, WA 98195–7120, USA. E-mail: nsjecker@uw.edu

Lifespan Account (PLA) was first developed in *Just Health Care* (1985) and *Am I My Parents' Keeper?* (1988), and more recently discussed in *Just Health* (2008). According to PLA, when we view our lives as a whole, rather than from a particular moment in time, it will sometimes be prudent for us to prefer a health care plan that distributes fewer services to our old age in exchange for more services earlier in life. So understood, age-based rationing is compatible with a principle of equality, as all are treated equally over time, reaping the benefits of access to more resources in earlier years and fewer in later life. A prudential planner makes allocation decisions only after giving equal consideration to each stage of his or her life. So understood, PLA recasts the problem of allocating health care between competing age groups as a first-person problem of prudence. We are to consider what is prudent for us to do for ourselves over an entire lifetime.

Daniels's proposal has been discussed at length in the literature, and important objections have been raised against it. Notwithstanding these objections, PLA continues to dominate scholarly debates about age-group justice. In this article, I propose a new objection to PLA, one that develops primarily out of the well-established disability critique of social contract theories. The objection challenges not only the specific proposal for age-based rationing, but also the broader framework of prudential reasoning across the life span that characterizes PLA. If my reasoning is persuasive, we need to look elsewhere for a solution to the problem of allocating health care among age groups. In the final section, I suggest a more promising avenue for addressing age-group justice.

OBJECTIONS TO PLA

Since the original formulation of PLA (Daniels 1985), several distinct types of objections have been raised. One type of objection holds that PLA cannot be action-guiding. First, startup problems arise when we try to implement age-based rationing. This is because the first age group to experience age-based rationing will be elderly people who will not experience the beneficial trade-offs promised earlier in life. Related to this problem is the concern that a health care budget allocated to different birth cohorts must first be in place before prudential planners can determine its allocation across the life span, and this requires first solving the problem of justice between birth cohorts (Brauer 2009). It has also been noted that prudent deliberators are to assume that they will live through each stage of life under the institutions they are designing. Yet critics emphasize that in reality not all individuals actually live complete lives of equal length. In practice, some individuals will reap the benefits of more resources early in life, but will die before they are required to sacrifice resources later in life (Lazenby 2011). Critics conclude that even if PLA can tell us how to allocate health care in a world where all individuals live complete lives of equal length, it cannot tell us how to make allocations in the actual world where the complete lives assumption is not met.

In partial response to these kinds of objections, Daniels has argued that the problem of justice between birth cohorts is independent from the problem of justice between age groups, and must be solved separately (Daniels 2009). He clarifies that when we refer to "birth cohorts," we are referring to distinct groups of people born at distinct times. Birth cohorts age over time, and special justice questions may arise for birth cohorts due to particular facts about their history. By contrast, when we refer to "age groups," we abstract from the distinctiveness of birth cohorts. The designation of an "age group" refers to people solely by reference to their place in the life span. Thus,

> Our question about justice between age groups also abstracts from the particular differences between the current elderly and the current young that arise because of the distinctive features of the birth cohorts that happen to make up those age groups. We are concerned with a common problem of justice between the old and the young that persists through the succession of aging birth cohorts. (Daniels 2008a, 170)

A second type of objection, often referred to as "the multiple self-objection," begins with the observation that an individual's preferences may change profoundly over the years. This renders budgeting health care over a lifetime difficult because it becomes unclear what set of preferences should be pivotal in devising a prudential plan (Schefczyk 2009). The prudential planner must act in favor of either one set of preferences or another, but there seems to be no rational basis for choosing. If prudential planners were age neutral, presumably they would give the same weight to each set of preferences. Yet this could produce irrational conclusions. For example, one might be required to act both for and against one's present preferences. Even thornier problems arise when one considers the possibility not only of profound preference changes, but of deeper disruptions of personality or cognition (Brock 1988). For example, a severely demented elderly person might not remember experiences from the past and might fail to recognize family members and friends. The prior person and the demented person may have different interests, personalities, characters, and so forth. All told, it might be more accurate to think of the demented individual as a successor to the person who existed prior to onset of the dementia, rather than as one and the same person. If this is right, PLA gives little guidance about how to make allocation decisions. As Brock notes, Daniels must assume that the personal identity of the allocator is maintained throughout the different stages of the single life to which resources are to be allocated, for only then can the allocation be framed in terms of the prudential reasoning of a single person concerned only with outcomes for him or herself at different stages of his or her life (1988). The view Daniels assumes is that identity over time is based on physical continuity of the body over time. Yet this view has been profoundly challenged (Parfit 1984). Thus, it has been argued that physical continuity is not sufficient, in the absence of psychological continuity, to establish that the patient is the same person, or even a "person" at all. If an individual cannot survive the destruction of psychological connections and continuity, it is not at all clear that the prior person has any moral authority to speak for or make health care allocation decisions on behalf of his or her successor.

A final set of objections to PLA addresses the fact that declining populations in developed countries threaten the stability of so-called "pay as you go" solutions to the age-group problem. Intergenerational compacts can be difficult to sustain when the size of the working age population declines substantially, and the burden placed upon this group to care for the dependent old increases. Moreover, as societal aging begins to impact more nations worldwide, including developing nations, the possibility of increased migration of young workers from other countries is no longer available to ease the burden of a shrinking workforce in developed countries. To address such concerns, Daniels argues (2008a; 2008b; 2009) that PLA must ultimately be supplemented by a fair procedure, such as accountability for reasonableness, and by an added focus on the social determinants of health. I discuss this supplemented approach in more detail below.

THE DISABILITY OBJECTION TO PLA

The objections just described have been addressed at length in the literature, and it is not my purpose to consider them anew. Instead, I want to explore a different type of objection, one that I argue carries implications not only for age-based rationing, but for PLA more broadly. This objection begins by focusing on what I call the equality requirement (ER). ER holds that we should give equal consideration to all parts of our life. It might appear at first glance that age-based rationing violates ER because it treats the young and old unequally. Yet, as noted already, defenders of age-based rationing argue that their approach is perfectly compatible with the value of equality. The requirements of ER can be fully met, provided justice principles are ones that all of us would agree to accept. Justifiability to all upholds ER by requiring each person's consent and thereby considering each person's needs and preferences equally. It ensures the equal dignity of persons, because no one's dignity will be violated by subjecting them to principles they would reject. The idea of justifiability to all is often incorporated into justice theories by means of the device of a social contract, which requires individuals to come together and "contract" or agree to certain principles that they will then be subject to. PLA amends this strategy by introducing the device of a prudential planner. Each of us is asked to come up with our own distributive principles for allocating health care to different stages of our own life. In this way, equal consideration is given to the preferences of our self at each stage of life. This approach requires that prudential planners can assume an "age-neutral" stance when making decisions about how to allocate health care across their life span. An age-neutral stance might be established, for example, by placing prudential planners behind a Rawlsian-style "veil of ignorance" in which they are assumed to be ignorant of important facts about themselves, including their present age (Rawls 1971). This would presumably limit the ability of prudential planners to design principles in a way that favors their present age. Daniels recommends such a strategy when he refers to "veiled prudence" (Daniels 1988, 56). Rejecting the perspective of the fully informed rational consumer, he prefers instead the assumption that prudential planners would be equally concerned about all parts of their lives in a time-neutral fashion.

Yet this line of reasoning does not take us very far toward solving the requirement of equal concern. It is not enough to say that prudential deliberators will pass through the various stages of life; what is instead required is that deliberation could, at least in principle, occur at any life stage. Only if it were possible for individuals to deliberate at each and every stage of life from a first-person point of view could prudential planners place themselves under a veil of ignorance and reasonably assume that they could be members of any age group. Expressed differently, the condition of justifiability to all, mentioned earlier, cannot be met unless we could, at each stage of our life, consider and agree to justice principles. However, such a possibility could never be fully realized, for at both ends of the life span, our situation is similar in key respects to the situation of persons with lifelong disabilities. Just as persons living with chronic intellectual impairment may not be able to participate directly and on their own behalf in consenting to justice principles, so too healthy children lack the cognitive capacity to participate directly in choosing justice principles. Although in healthy children this deficit is temporary and due to immaturity, the practical result is the same, namely, consent is unattainable. At the other end of the life span, people are living to older and older ages. While babies born in 1900 did not live past age 50, life expectancy at birth now exceeds 83 years in Japan—the current leader—and is at least 81 years in several other countries (National Institute on Aging and World Health Organization 2011). As people age, their risk of dementia increases. Thus, the prevalence of Alzheimer's disease and other dementias is very low at younger ages, then nearly doubles with every 5 years of age after age 65 (National Institute on Aging and World Health Organization 2011). According to a recent study by the Organization for Economic Cooperation and Development, dementia affects fewer than 3% of those aged 65 to 69, but almost 30% of those aged 85 to 89; more than half of women aged 90 or older living in France and Germany have dementia, as do about 40% of women over age 90 living in the United States (Oxley 2009). Although early-stage dementia may interfere only mildly with cognitive tasks, the final stages of dementia result in a loss of memory, reasoning, speech, and other cognitive functions. Due to the high prevalence of dementia, the oldest old are frequently unable to understand and consent on their own behalf to justice principles.

These kinds of considerations create a problem for PLA, which is similar in key respects to the problem noted by disability critics of social contract approaches to justice (Nussbaum 2006; Kittay 1999). These scholars have objected to social contract theories of justice on the ground that some individuals with intellectual disability are excluded from contracting. Similarly, I am arguing that the very young and many of the very old cannot engage in the kind of prudential planning PLA requires. Like social contract theories, PLA cannot meet ER by imposing a requirement of justifiability to all.

Let us explore more closely the objections of scholars such as Kittay (1999) and Nussbaum (2006) who raise concerns about the requirement that deliberators be regarded as mentally able to participate fully in schemes of cooperation. The difficulty Kittay finds with such an assumption is that it cannot possibly be met by never-competent individuals. Yet perhaps we can simply suppose, for the purpose of hypothetically deliberating, that a disabled person is suddenly lucid enough to participate fully in a cooperative scheme and a deliberative process. Unfortunately, this approach does not succeed. After all, many individuals with intellectual impairments not only lack the capacity to make their own decisions, they also do not have a past record of decisions, from when they had capacity, to guide us in making decisions for them. For this reason, Kittay contends that they represent a difficult group for contractarian theory.

Like Kittay, Nussbaum argues that persons with cognitive impairments create special problems for contractarian accounts of justice. Nussbaum proposes that a test we should apply to all candidate theories of justice would be: "Ask of each of the theories how the principles they suggest would treat the entitlements of people with cognitive disabilities, and we find fault with theories that, however attractive in other respects, cannot handle that issue well" (Nussbaum 2009, 331). According to Nussbaum, contractarian theories fail the test. Specifically, since some mentally impaired individuals cannot possibly be contracting agents, their concerns can be dealt with only as an "afterthought," that is, after the basic institutions are already designed (Nussbaum 2006, 98). Yet dealing with cognitive disability at a later stage in effect denies equal citizenship to people with cognitive impairments. Elderly people with Alzheimer's disease, for example, are disadvantaged in such a scheme because the basic social institutions are not designed for or by people with such impairments. From a practical standpoint, one worry is that investments in caring for cognitively impaired citizens may be shortchanged if it is considered a derivative issue. As Nussbaum notes, the kind of care that a decent society provides to people in times of unusual dependency, including not only special education treatment and redesign of public spaces, but also assistance with activities of daily living, might be affected. She uses as an example Rawls's theory, and notes that the primary goods of income, wealth, power, and authority that Rawls introduces reflect the needs of citizens who have the capacity to be fully cooperating members of society.

What I am arguing here is that the concerns raised regarding justice for mentally impaired individuals arise in a particularly striking way in the context of age-group justice. On the one hand, the very young have never been competent, even though they will presumably become so as they age. Therefore, any account of justice that begins with the premise that citizens have cognitive rational powers sufficient for choosing principles of justice cannot include the very young. On the other hand, the very old experience dementia at significantly higher rates than younger people do, and many lack the requisite cognitive ability to deliberate about and choose principles of justice.

It might be thought that a similar argument can be made about persons with physical impairments. After all, neither the very young nor the very old are physically able to participate fully in schemes of cooperation. Granted, the degree to which the young and old participate is to some extent an artifact of culture. For example, countries with less stringent child labor laws include children in the paid labor force. Likewise, the elderly as a group remain productive for many more years in societies in which there are social roles affording them the opportunity to remain active. Nonetheless, this kind of reasoning can only take us so far. After all, infants and toddlers cannot by any stretch of the imagination be said to "participate fully" in a cooperative scheme. Similarly, as people age, they are increasingly excluded from full participation as a result of disabilities that interfere with activities of daily life. For example, among people aged 21 to 64 living in the United States in 2010, 21.3% had a disability, compared with 49.8% of those aged 65 and older (U.S. Census Bureau 2010).

Despite the apparent similarity between persons with mental and physical impairments, persons with physical impairments possess the capacities required to participate in a cooperative scheme and agree to a social contract. According to Rawls, the requisite capacities for participating in a social contract include

> first . . . , a capacity for a sense of justice that enables [persons] . . . to understand, apply, and to act from the reasonable principles of justice that specify fair terms of social cooperation. The second moral power is a capacity for a conception of the good: a conception of the ends and purposes worthy of our devoted pursuit, together with an ordering of those elements to guide us over a complete life. (Rawls 1993, 103–104)

Given the cognitive nature of the moral powers required for contracting, those with physical impairments could, in principle, participate in a social contract to the same extent as those without physical impairments, provided that they were afforded the opportunity to do so. For example, someone with congenital deafness could be accommodated and, given the right tools, could be a fully cooperating member of a cooperative scheme. By contrast, an individual with severe cognitive impairment, such as static encephalopathy and cognitive functioning equivalent to that of an infant, would lack the basic mental capacities that are required to develop the two moral powers to the requisite degree. The severely intellectually impaired individual would inevitably be excluded, whereas the physically impaired person need not be. Critics regard the exclusion of persons with intellectual impairments to be an unacceptable and "implausible" outcome of social contract theories, and cast doubt on the ability of social contract theory to ever remedy it (Brighouse 2001, 560).

The exclusion of so many members of young and old age groups from prudential deliberation serves to undercut the idea of veiled prudence. For the whole point and purpose of such a veil was to guarantee ER: the equal consideration of individuals' preferences and needs across the life span. This concern cannot be dealt with or mitigated by merely imagining that elderly persons with profound dementia, or healthy newborn infants, are suddenly able to think and reason about justice. For the very young are not able to deliberate, *qua* young people, about justice for their age groups. Similarly, demented elderly persons are not able to think about justice for themselves as such, but only if they were suddenly imbued with capacities that made them nondemented. Merely assuming that infants are mature, or that the demented are mentally able, inevitably involves projecting one's own, adult and mentally capable, point of view.

Yet perhaps Daniels need not require that a demented self be suddenly lucid, as Kittay suggests, and need only require that the preferences of one's prior capacitated self are morally valid for and apply to one's later, demented self. Does this adequately address the problem? It is at best a partial reply, for it does not yet deal with Kittay's central concern, which is with persons who have never had mental capacity and thus have no prior capacitated self to render decisions. Moreover, in the limited case of cognitively impaired elderly individuals who previously had capacity, other difficulties emerge as we begin to unpack the assumptions associated with PLA. As Daniels notes, he borrows Rawls's apparatus for solving the general problem of justice, importing most, although not all, of its features to address the specific question of justice between age groups. Thus, he assumes that the mere fact that prudential planners have a "concern for their own lifetime well-being will require them to abstract from full information in order to be neutral about each stage of their lives, at least when they are considering the design of institutions that affect them over the whole lifespan" (Daniels 1988, 62). Yet the fact that all stages of my life are stages of *me* does not suffice to show that I care equally about all stages. As McKerlie notes, a prudential chooser not knowing how long she will live may have reason to favor earlier over later stages of life, rather than adopting an age-neutral stance (McKerlie 2002). In other words, since future-me is temporally distant and may never exist at all, I might rationally discount future-me relative to present-me, or even disregard a distant-future-me altogether.

In response to this objection, Daniels has emphasized that parties assume that they will live through the whole life span; as a result, "if we do not fund adequate care in our old age, we must be prepared to live that stage of life having traded care away for benefits elsewhere in our lives" (Daniels 2008b, 485). Yet this response is only partly successful. Even if prudent allocators would not discount future selves entirely, they might still favor a younger, able-bodied stage of life. Negative cultural attitudes toward old age and disability may influence a prudent deliberator and affect the choice of distributive principles. Thus, a prudent deliberator may devalue an old self and prefer to devote more resources to ensuring his or her well-being during more "productive" middle years. After all, nothing in the design of PLA prevents bias from intruding into prudential deliberation. Even though prudence inclines us to look out for and protect our own best interests, it does not create an impenetrable shield against bias. As Young (1990) notes, oppression can take the form of "cultural imperialism," in which a dominant group's experience and culture is universalized and established as the norm. Those who do not belong to the dominant group are labeled deviant and are defined according to the dominant group's stereotypes of them. This form of oppression is particularly insidious because it is internalized as a norm and leads people to devalue both others and their own "deviant" selves. A prudent deliberator who has internalized social biases against the old may devalue his or her own aged or disabled self, giving more weight to a younger or able-bodied stage of life. This form of self-deprecation is supported by recent research on unconscious bias. Greenwald, for example, reports that 80% of all Americans have a stronger "young = good" association than "old = good" association, and this association is just as strong for elderly respondents as for young respondents (Greenwald 2013). The implications for PLA are of concern. A prudent deliberator, p_1, who is able-bodied at time t_1 may discriminate against both another person, p_2, who is disabled at time t_2, and against her own future self, p_1, who becomes disabled at t_2. The fact that p_1 at t_1 is the same person as p_1 at t_2 does not suffice to protect p_1 at t_2 against being the victim of this bias. Not only does prudence fail to fully protect me from myself, it may fail to provide any measure of protection at all. In other words, there is no reason to think that p_1 at t_2 is less likely to be discriminated against by her former self, p_1 at t_1, than by another person, such as p_2. Those who harbor bias against the old or disabled may readily become their own victims, loathing the qualities in themselves that they regard as "deviant" and unacceptable. If my reasoning is sound, it follows that prudence alone does not satisfy the requirements of ER; it cannot be relied upon to safeguard the interests of people at each stage of life.

It is worth noting that persons with physical impairments are just as vulnerable to invidious discrimination as other groups are, and in this way their impairments can be disabling. It is useful to distinguish, as Garland-Thomson does, between "impairment," which refers to a bodily state or condition taken to be impaired, and "disability," which refers to the social process of disablement that gives meaning and consequences to those impairments (Garland-Thomson 2011, 591). Prudent deliberators allocating services to their future selves may devalue the physical decline or impairment of a future self, just as they devalue being old. In this way, physical impairments present a formidable challenge for social justice theories despite the fact that physically impaired persons have the cognitive capacity to participate fully in social contracting.

Finally, since PLA is grounded theoretically in a Rawlsian account of justice, it is worth noting that Rawls himself assumes that parties in the original position are intellectually competent. In *Political Liberalism*, Rawls states, "Since we begin from the idea of society as a fair system of cooperation, we assume that persons as citizens have all the capacities that enable them to be cooperating members of society" (Rawls 1993, 20), and "We say that a person is someone who can be a citizen, that is, a normal and fully cooperating member of society over a complete life" (Rawls 1993, 18). This idealizing assumption has led some disability theorists to conclude that Rawls cannot possibly provide for the justice claims of people who are unable to participate in the contracting process, or are unable to contribute to the production of goods required to sustain themselves. Elsewhere, Rawls characterizes deliberators in the original position as the heads or representatives of families (Rawls 1971); however, critics point out that heads of families are not well situated to determine questions of justice within families, including questions of justice between generations (Okin 1989).

RESPONDING TO THE DISABILITY OBJECTION

In thinking about the objections just discussed, it is helpful to consider Daniels's most recent work, which amends some of the key points in his original formulation of PLA. Daniels has argued, for example, that prudent deliberators would want their lives as a whole to go as well as possible, but now acknowledges that this requires more than simply maximizing some quantity, such as welfare, healthy life years, or overall well-being, as he originally proposed. Instead, prudence may require "a more complex or nuanced judgment about how certain needs are met and exercisable opportunities provided at various stages of a life" (2008b, 485). On this more complex account, life as a whole cannot be said to "go as well as possible" if basic opportunities and important needs are not met at each stage of life, even if the overall level of well-being is maximized. Daniels holds that it is a requirement of justice that individuals can compete as equals in all areas, especially for jobs and careers, and that society is obligated to fund treatments that interfere with age-related normal functioning. While this approach is "more complex" than the simple idea of maximizing lifetime well-being, Daniels reasons it is "not less justifiable" (2008b, 488). Still, he admits that "the criterion for what makes a life go as well as possible is less clear than I once thought" (2008b, 490).

How do prudent deliberators render these more complex, less clear judgments and come up with justice principles for allocating health care across their life spans? Daniels proposes that arriving at such judgments requires more than prudence alone. It also requires appealing to a fair process: "If we have persistent disagreements about principles for resolving rationing problems, then we must retreat to a process all can agree is a fair way to resolve disputes" (Daniels 2001, 10). Perhaps Daniels envisions the approach would unfold in a stepwise fashion. First, we use prudential reasoning to arrive at principles for allocating health care across our life span. Next, we resolve more complex disputes about what it means for a life to go as well as possible through a fair process. One example of a fair process is accountability for reasonableness (Daniels and Sabin 2002; 2008), which aims to hold decision makers accountable for the reasonableness of their decisions by requiring a process that is public about the grounds for a decision, rests on reasons that stakeholders can agree are relevant, and is open to revision in light of new evidence and arguments. Moreover, adequate enforcement of these conditions (publicity, relevance, and revisability) must be in place to give people assurance that the conditions will be met. On this revised approach, a prudent deliberator attempts to determine what allocation makes life go as well as possible. When prudence cannot make this determination,

> judgements about what is prudent become contested in the way that interpersonal judgments about fairness are. If we invoke accountability for reasonableness to resolve disagreements about what counts as prudent in general or about what health care allocation makes a life go as well as possible, then we might seem to be no better off than if we were dealing with interpersonal issues [between age groups] in the first place. Nevertheless, even if some of the simplicity of the proposal is reduced, we can in this way reach some agreement on what allocations of health care resources make lives go as well as possible. If we then apply such schemes to all persons over their lifespan, then we are not treating age groups unfairly. (Daniels 2008b, 488)

The revised account supplements PLA by introducing an entirely new mechanism for rendering judgments about allocating health care across the life span. Prudential reasoning focuses on the task of allocating one's own resources to different stages of one's own individual life, whereas a fair process like accountability for reasonableness focuses on a different task. It returns us to the interpersonal realm, where we engage with others to make decisions affecting multiple stakeholders. When asked to identify relevant reasons supporting our judgments, our reasons will appeal to more than prudence, since prudence alone could not solve the complex questions the fair method was called upon to settle.

Does accountability for reasonableness avoid the objections just raised? Can it avoid cultural imperialism? Does it give equal consideration to individuals at each stage of life? Consider first the objection based on cultural imperialism. We can easily imagine a society whose members are biased against the elderly, the disabled, or some other group, and yet met all of the requirements of a fair process, such as accountability for reasonableness, and ended up with blatantly discriminatory distributive principles. As Fleischacker notes, for most of human history practically no one held, even as an ideal, the view that everyone was equal, or that "everyone should have their basic needs satisfied" (Fleischacker 2004, 2). Since a fair process removes the idealizing assumptions contained in PLA, it allows biases to enter even more directly. Since the veil that prevented deliberators from knowing their age is now lifted, whatever protection it afforded against bias and discrimination, however inadequate, would no longer be in force.

Accountability for reasonableness fares no better when we consider the requirements of ER. Justifiability to all would presumably require that everyone could, at least in principle, participate in a process of determining what makes a life go as well as possible. But the very young and the disabled old lack the ability to be full participants in this process. Daniels attempts to ensure that the requirements of ER are met by means of a Rawlsian-type principle requiring fair equal opportunity for individuals at each stage of life. He insists that society has an obligation to ensure that departures from normal species functioning are corrected so that people can compete equally, especially for jobs and careers. For example, he states that even if we reduce risks to population health in an equitable fashion, people will still become ill and impaired and we will still have to devote resources to personal medical services and other forms of social support for people—yet how much we do will depend on "careful deliberation by a fair process . . . to determine the proper allocation of resources" (Daniels 2008a, 143). However, it is unclear, as Seagall (2010) points out, that this view goes far enough. For example, it appears that society does not have an obligation to pay for ordinary vaccinations for conditions to which we are all susceptible. After all, being immune to a condition such as polio represents a departure from normal species function, while being susceptible to it does not. Another concern with the standard of "normal functioning" is that Daniels makes it age relative; thus, we need to ask whether the high incidence of dementia among the oldest old would place the mentally impaired elderly beyond the reach of basic health services. What about those who live beyond a normal life span? Are centenarians entitled to health care services, and if so, is their priority lower relative to persons who have not yet reached a normal life span?

One way of responding to such concerns would be to try to shore up the requirement of justifiability to all by arguing that the very young and the very old need not represent themselves directly either in a fair process or in prudential deliberation about allocation across the life span. Instead, they can be fairly represented by a surrogate who looks out for their best interests and ensures that these interests are taken into account in devising justice principles. For example, guardians of infants can vote on infants' behalf and in consideration of infants' best interests (Nussbaum 2009). This approach, widely used in health care when surrogate decision makers act on behalf of minor children, strives to take into account an infant's own best interests. For individuals with prior capacity, guardianship makes practical use of the knowledge the guardian has of an individual's prior wishes (Lindemann 2009). While it is not without difficulties, it could be argued that this strategy at least attempts to give equal consideration to the interests of people who lack the cognitive capacity to be fully cooperating members of society.

In considering this proposal, it should be noted that in PLA the decision maker is not a true "surrogate," that is, one person taking the place of another person. Instead, decisions are designed to be made from the first-person perspective of an adult looking back and looking forward over his or her entire life. Prudential planners view their lives as whole, and decide for themselves how services will be distributed across their life span. Nonetheless, it could be argued that prudential planners are similar to surrogates in the sense that they function like stand-ins for their past and future selves, in the same way that surrogates stand-in for others. Moreover, to the extent that the multiple self-objection discussed earlier succeeds, and the personal identity of the prudential planner is not maintained throughout the different stages of life, the prudential planner would qualify as a surrogate in the stricter sense of one person substituting for another. On this conception, prudential planners render decisions for others, that is, their predecessors and successors, rather than for earlier and later stages of their own lives.

Another possibility, which applies to the case of healthy infants, argues that a future adult will be able to participate fully in the bargaining process associated with prudential deliberation. In other words, having the potential to develop the capacities required to participate fully in a social scheme might thus ensure one's eventual inclusion (Wong 2009). Yet this move is not particularly helpful. To represent infants as equal citizens requires that their needs and preferences *as infants* are given equal consideration. The infant *qua* infant can never participate in this fashion, even though the infant is obviously a fellow citizen and participant in human dignity. Likewise an infant, *qua* infant, can never vote in an election, serve on a jury, or make health care decisions. While a guardian can stand up for (the guardian's own conception of) the infant's best interests, the guardian cannot represent an infant's preferences, since an infant is presumably unable to form preferences. For this reason, the infant is not truly participating, and the guardian is replacing, rather than representing, the infant. This point resembles the claim by Wasserman and McMahan, who argue that surrogates can provide, at best, "counterfeit equality" for those lacking practical rationality or self-consciousness (Wasserman and McMahan 2012, 325). They note that acts done on a disabled person's behalf may be "too attenuated for those acts to count as his own, either for realizing moral or political equality or for enabling him to participate in a human community or human forms of life" (Wasserman and McMahan 2012, 325).

Another concern with an emphasis on surrogacy and guardianship with regard to people with severe and profound cognitive impairment is that it is at odds with the emphasis in much of the disability studies literature, which focuses on the self-representation of people with disabilities (Berube 2009; Hacking 2009; Nelson 2009).

THE CAPABILITIES APPROACH

If prudential deliberators cannot fairly and equally represent both their "younger" and "older" selves, it would be difficult to justify age-based rationing of health care based on PLA. It also would be difficult to justify PLA as an approach for dealing with age group justice questions more broadly. What is the best alternative? What does the best alternative tell us about age-based allocation and rationing of health care? While fully answering these questions is beyond the scope of this article, I want to suggest a promising pathway for addressing these concerns.

One response to disability critiques of Rawlsian-based social contract views has been to replace Rawlsian bargaining with an approach that avoids creating outliers of those who do not possess the qualities essential for contracting. For example, Silvers and Francis (2005) develop an account that builds on people's capacity for trust and for developing bonds of confidence with each other. They claim that this account dispenses with the requirement for threshold levels of ability to present one's viewpoint, to strategize against others so as to promote one's viewpoint, and to contribute to others so they value one's viewpoint. If successful, a non-Rawlsian style of contracting could support developing distributive principles that are fair to vulnerable groups. However it is difficult to see how this approach would carry over to the type of first-person prudential reasoning required for PLA. How would a first-person prudential deliberator rely on trust and human interaction to forge principles for allocating health care throughout his or her life span? Even if trust-based accounts of social contracting can be developed for distributing resources among different individuals and groups in the society, it is unclear how such an account would work in the case of first-person prudential reasoning.

I believe that a more promising strategy is to set aside social contracting and rely instead on something like the capabilities account of justice advanced by Nussbaum (2006; 2009; 2011). According to Nussbaum, a capabilities approach begins with a conception of the person as a social animal, whose dignity "does not derive from an idealized rationality" (Nussbaum 2006, 99). Nussbaum seeks to establish a set of basic capabilities required for human flourishing, and argues for equality of these basic capabilities. She maintains that justice requires that each and every person, regardless of age or disability, be sustained in each of their basic capabilities at a threshold level required for human dignity (Nussbaum 2000; 2006). These capabilities, which include among others life, health, affiliation, practical reason, and control over one's environment, comprise a fundamental, or prepolitical, entitlement. In considering the just allocation of health care between age groups, the capabilities approach focuses our attention on the impact age-based rationing is likely to have on the central capabilities. Since it requires that everyone be maintained at a threshold level, certain forms of rationing would not be allowed, and trade-offs between young and old would not be justified if they result in a reduction of certain capabilities below the minimum level.

The capabilities approach makes evident that the requirements of justice can be conceived of in a manner that is quite independent of whether or not individuals rationally agree to accept certain distributive principles. According to the capabilities approach, what is necessary and sufficient to justify a particular allocation is to show that it maintains people's basic functioning and capabilities at a sufficient level. In other words, the capabilities approach imposes an objective standard, the sufficiency requirement, and requires that everyone be brought up to the level of human dignity set by this standard.

Notice too how an emphasis on human capabilities differs from an emphasis on resources. After all, bringing everyone up to a threshold level of basic capabilities is not simply a matter of giving everyone access to a basic resources, or giving resources to the least well off. This is because there are varying needs for health care based on people's varying abilities to convert resources into functioning and capability. For example, the elderly experience higher rates of chronic illness and disability than other age groups, so it can take more health care to achieve the same level of basic functioning capability for them. Expressed differently, it can be harder for the elderly to convert income used for health care purchases into capability, since

> an older, or more disabled or more seriously ill person may need more income (for assistance, for prosthetics, for treatment) to achieve the same functionings [as non-handicapped individuals]. . . . Thus real poverty (in terms of capability deprivation) can easily be much more intense than we can deduce from income data [alone]. (Sen 2009, 256)

An approach to justice that looks only at lifetime costs of care, or only at the goal of equality in the distribution of resources, might miss the unique features of caring for the chronically disabled (Silvers 2012).

In addition to health status, many other factor influence people's ability to convert resources into real functioning and capability. Social determinants of health play an integral role. For instance, an elderly person living in poverty may be unable to afford her share of costly medications, even when health insurance covers a portion of the cost; likewise, an elderly person without access to public transportation may be unable to participate in rehabilitation services provided outside the home, even when such services are available in her community. A capabilities approach aligns with what we know about the social determinants of health (Jecker 2008). Emphasizing capabilities also forces us to take into account the impact of social norms and stereotypes (Robeyns 2010). For example, it requires us to think about how ageist attitudes or social biases against people with intellectual or physical impairments may affect those people's ability to convert resources into real functioning and capabilities.

Another way in which the capabilities approach differs from and improves upon a social contract approach is by furnishing an account of what we owe to individuals with cognitive impairments. This problem arises not only in the special case of persons with chronic intellectual impairments, but also at both ends of a healthy life span. When an individual cannot rationally deliberate, we cannot, even hypothetically, consider what that person would want from that person's point of view. Moreover, the asymmetry of power between a cognitively intact adult and an infant, or between a cognitively intact adult and an adult with late-stage Alzheimer's disease who cannot hold a conversation or respond to the environment, is too great for us to even imagine a hypothetical agreement taking place. In these instances, the capabilities approach can do for us what social contract approaches cannot, namely, support a set of basic entitlements for everyone that make possible a life with dignity.

Another way in which the capabilities approach is distinct is that it attaches some degree of moral and political importance to species membership. The kind of functioning that is characteristic for a species is what establishes the central capabilities and associated obligations for each species member. In this way, the capabilities approach distinguishes one species from another. According to Nussbaum, for example, comparing the functioning and capabilities of a human with those of a nonhuman misses the mark, even if in an individual instance the functioning and capabilities are comparable. She gives the example of a child born with Down's syndrome, and argues that

> it is crucial that that the political culture in which he lives make a big effort to extend to him the fullest benefits of citizenship he can attain, through health benefits, education, and the reeducation of the public culture. This is so because he can only flourish as a human being. He has no option of flourishing as a happy chimpanzee. For a chimpanzee, on the other hand, expensive efforts to teach language, while interesting and revealing, are not matters of basic justice. A chimpanzee flourishes in its own way, communicating with its own community in a perfectly adequate manner that has gone on for ages. (Nussbaum 2004, 310)

Finally, it is worth noting that the capabilities approach is at its core egalitarian. It sets for everyone the goal of attaining an adequate or sufficient level of their human capabilities to the extent possible. It allows us to look at a whole range of human experience, and to emphasize the equal moral worth and dignity of diverse individuals. In this way, the theory underscores our common humanity with others. Unlike Rawlsian-based social contract views, which hold that principles of justice are initially chosen for those who are "normal and fully cooperating member[s] of society over a complete life" (Rawls 1993, 18), the capabilities approach furnishes a broader view. According to the capabilities approach, the scope of justice is not confined to those who have the same mental and physical abilities we do, but instead encompasses a diverse group of people, whose physical and mental abilities are unequal. Despite all the differences among humanity, the capabilities approach identifies an underlying equality that is rooted not in rationality per se, but in a wider range of central capabilities we identify as human.

Daniels himself considers the claim that we should be focused more on whether individuals have the appropriate set of capabilities to do or be what they choose, and less on the allocation of health care resources to treat conditions that represent a departure from normal opportunity (Daniels 2001). His response is to point out that the practical difference between this view and his own may not be as great as it at first appears, even though the theoretical differences remain. Elsewhere, he suggests that "despite the difference in terminology –capabilities versus opportunity—the two views largely converge" (Daniels 2008a, 70). Finally, Daniels suggests that his own extension of Rawls's theory to health and health care is not necessarily the only approach to developing a theory of justice.

Let us examine some specific age-based rationing proposals and see what the capabilities approach tells us about these proposals.

1. *Rationing publicly-funded life-extending care to the elderly in order to provide other care to the elderly.* Would the capabilities approach allow policies that denied public funding of life-extending care to elderly people? What if the savings were used to underwrite the cost of health care services designed to improve quality of life for the elderly? Defenders of such a proposal (Callahan 1987; 2012) hold that "It is the obligation of a good society to help the young to become old but not to help old people become indefinitely older" (Callahan 2012, 14). Thus, after a certain age, it is claimed, people are no longer entitled to publicly funded life-extending care. The capabilities approach rejects any form of rationing resulting in any of the central capabilities falling below a minimal threshold. Yet maintaining everyone at a threshold level of the first capability, life, does not necessarily require society to pay for life-extending care regardless of age, but instead requires ensuring that everyone can reach the end of a human life of normal length. It might be consistent with the sufficiency requirement set by the capabilities approach to impose age limits on publicly funded life-extending care, such as kidney transplantation or dialysis, which is currently paid for in the United States without explicit age-based restrictions. Provided that an age-based cutoff occurred after a normal length of life, which is a changing rather than a fixed idea, the capabilities approach can allow it. According to this analysis, for example, people in their 90s might be denied a publicly funded kidney transplant without violating justice requirements. Although some societies may choose to do more, for example, funding dialysis and kidney transplantation for people of all ages, doing more is not necessarily required by justice.

Yet it could be objected that age-based rationing of publicly funded life-extending care would systematically disadvantage women (Jecker 1991) or other groups that are disproportionately represented among older age groups. Among those age 80 and over, for example, women are nearly twice as numerous as men, and among centenarians women are between four and five times as numerous as men (United Nations 2010). Moreover, since elderly women have on average more years ahead to live than elderly men do, denying elderly women life-extending care deprives them of more future life years than it denies to elderly men. Yet in response to these concerns, defenders of the capabilities approach can reply that after reaching a normal life span, neither men nor women are entitled to publicly funded life-extending care. Thus, even if women are disproportionately impacted by age-based rationing of publicly funded life-extending care, they are not being denied a resource that they are entitled to receive.

The widespread implications of age-based rationing of life-extending care for containing health care costs should not be missed. As the World Health Organization and the National Institute on Aging have reported (2011), global aging will accelerate the incidence of diseases, such as cancer, stroke, and heart disease, and raise ethical issues regarding interventions to extend life at increasingly older ages. Since the largest share of health care costs associated with advancing age occurs in the final year or so of life, and since people are living longer, the final year of life is occurring at older ages. Thus, if publicly funded life-extending care is denied after a certain age, the high cost of prolonging life in the final year would be significantly reduced.

What about the more specific proposal to trade off publicly funded life-extending care in old age for services that improve the quality of life for people in old age? The capabilities approach does not tell us what specific trade-offs to make in order to realize the sufficiency requirement. However, any trade-offs we make must bring all people up to the minimum level required for human dignity. This means that societies are left to work out the details of how to realize sufficiency. The proposed trade-off represents one possible way of moving closer to the threshold requirement in the area of long-term care. There are other, equally just, ways a society could move toward the sufficiency level, and the capabilities approach leaves open the question of which way to proceed. In the final analysis, "a just, deliberative, political process must be put into place, through which various proposals can be fairly debated and a definitive distributive policy eventually chosen" (Arras and Fenton 2009, 33). The capabilities approach can only take us so far. It can establish the value of capability equality and justify the goal of bringing everyone up to the level required for human dignity. Yet it cannot tell us how specifically we should go about divvying up resources and bringing everyone to the threshold level required by justice. In other words, the approach does not answer the question of exactly who should get exactly what. The parameters of justice are clearly necessary, even if they are not sufficient, for determining a system of health care allocation.

2. *Rationing publicly funded life extending care to the elderly in order to provide it to the young.* Consider a second rationing proposal, which consists of trading health care resources that increase a person's chance of living a longer than normal life span for health care resources that increase the chance of reaching a normal life span. Advocates of this approach (Daniels 1988) would say, for example, that we should invest scarce health care resources in prenatal care for pregnant women, rather than in acute care services for the terminally ill elderly. As noted already, the capabilities approach tells us that government has a justice duty to protect and secure our ability to reach a normal life span. How this is specified at a particular time and place in human history will depend in part on the state of medical technology, the wealth of a society, and other factors. The capabilities approach permits this trade-off and allows, for example, age-based rationing of costly, life-extending care, such as quadruple bypass surgery for someone in their 80s or 90s, when this frees up resources to use for primary care, such as prenatal services or childhood vaccines, that help to ensure that young people are able to reach a normal life span. The capabilities approach would also recognize as morally justified other possible ways of attaining the threshold requirement for the first capability of being able to live to a normal life span.

It might be objected that age-based rationing of life-extending care is never justified because it discriminates against people on the basis of a characteristic over which they have no control. We do not choose to age and die. Or it might be thought that age-based rationing is objectionable because it suggests that the lives of those who have lived beyond a normal life span are less valuable or worthy. Finally, it might be argued that age-based rationing is never justified unless those who are subject to its requirements agree to accept it. I submit that all of these objections miss the point. First, by grounding justice in features essential to a form of life that is human, the capabilities approach accepts human mortality as a given. A person who never grew old or died would not be living a human life as we understand it. Second, the justification for age-based rationing grows out of this, and does not require a further step, such as obtaining consent from the elderly. Consent is neither a necessary nor a sufficient condition for justice obligations. Finally, the capabilities approach assumes the equal worth and dignity of all persons, which is why it protects all persons equally in their basic capabilities up to the threshold required for human dignity.

3. *Rationing publicly funded long-term care to the elderly.* Let us consider a final age-based rationing proposal, one that focuses on support services that elderly people who experience limited mobility, frailty, or other declines in physical or cognitive functioning may require in order to accomplish activities of daily living. These are relatively inexpensive when compared to acute interventions, such as staying on life support or receiving an organ transplant. What is society's obligation to support such services? Would the capabilities approach allow age-based rationing of publicly funded long-term care services, such as home health care or skilled nursing home stays? In the United States, Medicare has historically denied coverage for these services when they fail to improve a patient's medical condition. Since chronic conditions, such as Alzheimer's disease, multiple sclerosis, Parkinson's disease, and stroke, tend to be progressive, elderly and disabled people have often failed to qualify for Medicare reimbursement. One result is that family caregivers often find themselves without relief, both financially and personally.

According to the capabilities approach, what is required in order to show that long-term care is a social obligation is to show that it is required in order to bring people up to the basic capabilities level that is required for human dignity. In other words, "our dignity is a legitimate source of entitlement" (Nussbaum 2006, 43). The basic capabilities at stake include not only bodily health and life, but also bodily integrity, which consists of being able to move freely from place to place. In order to ensure that people of all ages have a life worthy of human dignity, society is obligated to ensure that elderly people who have lost the ability to live independently have the opportunity to receive basic caregiving. The argument is not that we would want this level of care if we were to imagine ourselves as younger or older versions of ourselves. Instead, it is that to furnish less is to allow the most vulnerable among us to fall below a threshold level required for human dignity.

In the case of the U.S. Medicare program, which has denied payment for services that fail to improve a patient's medical condition, the capabilities approach would interpret justice as requiring government to bring people up to and sustain them at a minimum threshold. Specifically, government has an obligation to help the disabled elderly in the core entitlements implicit in the idea of a life with dignity. This obligation requires ongoing affirmative support. Recently, in a nationwide class-action lawsuit, the Obama administration agreed that Medicare would pay for skilled nursing and therapy services that maintain a patient's current condition or prevent further deterioration, even if no improvement is possible (Pear 2012). According to the capabilities approach, such an agreement represents an improvement in justice, because it helps to ensure a modest level of support for disabled and elderly people and for those who serve in a caregiving role. Although the settlement is likely to increase health care costs by requiring Medicare to pay more, such an increase is not only justified, but required by justice standards. It also may prevent more expensive care in hospitals and nursing homes that would be necessary if patients' chronic conditions were to deteriorate.

In contrast to life-extending care, which may be limited after a person reaches a certain age, there is no justification for age-based limits on basic caregiving. According to the capabilities approach, there is a binding obligation on society to ensure that health care systems are structured in such a way that the dependent elderly have access to caregiving services designed to ensure the threshold level of functioning and capability required for human dignity. This obligation can be specified and met in a variety of ways. In the United States, for example, unpaid caregivers provide an estimated 90% of long-term care for the disabled (Institute of Medicine 2008). Where family members provide care, society has a duty to ensure that family caregivers are not required to sacrifice their own functioning and capability to such an extent that they fall below the threshold level they are trying to provide to those they care for. Thus, even when family members are providing hands-on care, all members of society continue to have a collective justice obligation to ensure that the central capabilities of those being cared for are provided for, and that those providing care maintain a sufficient level in all the central capabilities. For example, society continues to be obligated to support caregivers' central capabilities by ensuring that they can make different choices, without sacrificing the dignity and well-being of care recipients. This point is especially relevant in light of the changing dependency ratio. There has been a global reduction in the number of working-age people compared to non-working-age people. As a result, there will be fewer working-age family caregivers available in the future to care for non-working-age family members.

CONCLUSION

In closing, while the arguments of this article do not rule out age-based allocation of health care, they show that arguing for or against such a policy must be approached in a different way. Some of the best defenses of age-based rationing, such as PLA, do not survive careful scrutiny. I have also argued that engaging in first-person prudential reasoning is not the best way to think about the allocation of resources between age groups, because this approach cannot fairly represent all age groups. Built into the structure of PLA is a bias that thwarts our ability to regard all people as equals. For this reason, we need to look elsewhere to solve problems of allocating health care between the young and the old.

The capabilities approach offers a promising alternative that avoids the kinds of problems to which PLA is vulnerable. The capabilities approach does not create outliers of those who lack cognitive capacities. Moreover, it pays close attention to the social determinants of health by considering whether or not people can convert resources into functioning and capabilities. Finally, it recognizes the equal worth and dignity of all human beings. When we reflect upon what we owe each other, the capabilities approach does not focus on autonomy and choice, but instead recognizes the vulnerability and dependency that each of us experience at different stages of life. By affirming the equal dignity of all human beings, the capabilities approach affirms the duty to support human dignity across the life span. ■

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