Policymakers should focus healthcare more on achieving wellbeing over whole lifetimes

*For complex anthropological, social, professional and legal reasons, many Western countries spend appreciable portions of their healthcare budgets on end-of-life care – between 13% and 25% of US Medicare budgets (depending on definitions). **Paul Dolan** uses a psychological model called 'Terror Management Theory' to make a personal exploration of the arguments for policymakers to assign a lower proportion of budgets to such purposes and to assign more influence to whole-life wellbeing.*

When Captain Sir Tom Moore died, there was a huge outpouring of grief. He had raised £33 million for the NHS during lockdown and that had made him a hero to many. But why were so many people so upset when a man they never knew lived to 100 and appeared to have had such a rich life, as well as a very long one?

Here (and in my Duck-Rabbit podcast) I want to look at what the last 18 months have taught us about the one certainty in life: death. In particular I wondered whether the policy response to the pandemic had meant we had become comfortable with prioritising the lives of the older people over those of younger people. During the pandemic, the dominant social narrative has been to 'preserve life'. This narrative prescribes that we should extend lives even when we incur significant financial and possibly net-happiness costs in doing so. At the same time as we spend up to 25% of the US healthcare budget in the last year of life (defined in different ways), higher levels of death anxiety adversely affect wellbeing.

A psychological model called Terror Management Theory posits that the fear of death drives much of human behaviour. We have an understandable fear of dying and it's hard for us to detach ourselves from this when we consider policy decisions and responses to pandemics. But we are all going to die, and one prescription the approach suggests is that we must do more to accept that, to discuss it with our loved ones, and to do all that we can to ensure that we have a good death insofar as that is possible.

In the UK, the government repeatedly said that its response was response to COVID-19 was guided by 'the science'. But the science is never clear-cut or complete, and it is much easier to 'sell' if it is underpinned by a clear narrative. Against the background of preserving life, various attempts to raise concerns about life experiences and lifetime wellbeing have been greeted with extensive moral outrage.

We know that prior to the vaccination campaign, the mortality and morbidity risks from COVID-19 increased significantly with age. Yet the social, economic, and educational burden of the pandemic has lain far more with younger and lower income people. If people's lifetime prospects are an important measure of human welfare, then my view is that we are likely to have engaged in one of the biggest redistributions of resources in human history, from those who have the least to those who have the most.

In my own empirical work, sampling 500 people broadly representative of the UK population, respondents put 'having lived less' life as their main reason for prioritising younger people in health care. This is consistent with the 'fair innings argument' (FIA) – the egalitarian principle that everyone is entitled to some 'normal' span of health (usually expressed by life years) and anyone failing to achieve it has been 'cheated'. Of course, such evidence does not suggest that the health needs of older people should be neglected because they have already achieved a fair innings, only that they should be afforded less priority for life-saving interventions than those who have not yet lived as long.

A more sophisticated version of the FIA would account for life experience as well as life expectancy. As private individuals and public citizens, all of us care not just about how long we and other people survive, but also about how well we thrive. This would mean that people who had suffered most over their lifetime would be given greater priority than those who have lived well. Therefore, younger people with pre-existing conditions at high risk of Covid would be afforded great priority.

Date originally posted: 2021-07-29

Permalink: https://blogs.lse.ac.uk/politicsandpolicy/healthcare-wellbeing/

Blog homepage: https://blogs.lse.ac.uk/politicsandpolicy/

In my view, our priorities should not be determined by Covid *per se*, or by any new virus or crisis we might face, but by the impact on wellbeing over the lifetimes of all those affected by it and the policy responses to it. We can't avoid making trade-offs between the needs of different age groups, even if these trade-offs are sometimes implicit or hidden. For instance, under current health spending constraints, a decision to spend more on geriatric care might mean there is less budget available to spend on paediatric care.

And I feel also that we must redouble our efforts to manage deaths properly, so as to create as much benefit as possible for the dying person – and, crucially, for those left behind. We must do more to accept death, especially in old age, and to minimise the impact that the death of loved ones has on family and friends. That means we need to have proper discussions about what end of life care looks like, and how we can best support patients and families.

Note: this article gives the views of the author, not the position of the LSE British Politics and Policy blog, nor of the London School of Economics and Political Science.

About the Author

Paul Dolan is Professor of Behavioural Science at London School of Economics and Political Science. He is the author of *Happiness by Design* and *Happy Ever After*, and host of the Duck-Rabbit podcast.

Photo by Marcelo Leal on Unsplash.

Date originally posted: 2021-07-29

Permalink: https://blogs.lse.ac.uk/politicsandpolicy/healthcare-wellbeing/

Blog homepage: https://blogs.lse.ac.uk/politicsandpolicy/