

Wealth Transfer through Voluntary Death

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K. K. Fung, PhD*

ABSTRACT. Today, the hopelessly ill who are insured must choose between futile treatment and prolonged morbidity. Legalizing physician-assisted death for the hopelessly ill would broaden patient choice and conserve scarce resources. To ensure that the saved resources will not be re-channeled to more futile treatments for other hopelessly ill patients, those who choose dignified passage should be allowed to determine how the saving from their refusal to a prolonged death is to be re-deployed. Converting projected entitlements into death benefits at a discount would not only reduce health-care and retirements costs but improve allocation of scarce resources.

A DIGNIFIED PASSAGE

At 65, Anglo Ronod is throwing a farewell birthday party in a dignified-passage clinic. Among his guests are his children and grandchildren, close relatives, good friends, physician, lawyer, pastor and representatives from charitable organizations. After Mr. Ronod found out he had Alzheimer's disease, he talked with his children and grandchildren about ending his life early. Although they don't completely agree, his children and grandchildren understand the wisdom of his choice. By dying earlier, not only can his savings be preserved, but his estate will be supplemented by the converted entitlements from Social Security, Medicare, and Medicaid. He could also donate his vital organs in the most usable condition. Most important of all, he does not have to choose between two equally unpalatable alternatives: enduring a cold and isolated existence in an alien nursing-home environment or imposing an interminable burden on his children's families.

His pastor calls the party to attention. He explains why Mr. Ronod chooses a dignified passage and praises Mr. Ronod for his generosity. Then Mr. Ronod's lawyer announces the beneficiaries of Mr. Ronod's converted entitlements. The local libraries, the Alzheimer's Disease Foundation and the National Arbor Day Foundation are among the 30 charities and non-profit organizations to receive gifts. The lawyer also announces the recipients of Mr. Ronod's organs. These recipients have all been tested for tissue compatibility and have agreed to forego their future reproductive rights.

Carrot juice, Mr. Ronod's favorite drink, is then served. The guests mingle with the enfeebled Mr. Ronod. An hour later, the pastor blesses and adjourns the party.

As Odetta's rendition of "Sweet Chariot" comes through the loud speakers, Mr. Ronod is accompanied by his physician and the pastor to the dignified-passage chamber. The pastor blesses the passage. When Mr. Ronod

is ready, he is anaesthetized and his usable organs are salvaged. When the last organ is retrieved, the passage is completed.

Mr. Ronod's passage is indeed dignified. By choosing an early passage, he avoids the indignity of dying a prolonged death amid feeding tubes. It is also a glorified passage. By dying early, he does his part in getting the Social Security, Medicare, and Medicaid programs out of their financial bind. Because 25 - 35% of Medicare expenditures in any given year go to only 5 - 6% of those enrollees who will die within that year (Callahan, 1987: 130), an earlier passage will help contain the seemingly uncontrollable health-care costs. By prearranging his organ donation, he ensures that his organs are in the most usable state. And by restricting the reproductive rights of the recipients, he ensures that those genetic defects that make organ transplants necessary will not be passed onto later generations.

Although Mr. Ronod is not a man with a substantial estate, he does own his home, a life insurance policy, and some savings in various forms. However, his estate has been substantially augmented by the incentives offered to him by the Social Security, Medicare, and Medicaid programs. These incentives represent 60% of the projected payments which these programs have to make if he chooses to die a slow death instead. Thus, except for the nursing home, the sickness-care establishment, and the life insurance company (which has to pay out the death benefits earlier while receiving fewer premiums), everyone else involved benefits from his dignified passage.

A BLOCKED EXIT

There is only one thing wrong with this scenario. Under current U.S. laws, this scenario just cannot be played out because it is illegal to assist early passage. Those who are compassionate enough to help often run afoul of the law. There is, however, a possible solution to this tragic impasse. When abortion was illegal before *Roe vs. Wade*, people with means went abroad to have the operation done legally. Today, the Netherlands offers euthanasia to terminal patients. Unfortunately, this service is not available to foreigners. Some Third World countries in dire need of foreign exchanges could conceivably legalize euthanasia to attract dignified passagers from the U.S. Just imagine what a boon it would bring to their economies! The businesses that are likely to benefit include airlines, funeral homes, and tourism. The overhead costs of building and operating dignified-passage clinics are low. No expensive medical equipment is needed, and the only medical personnel required would be those who salvage the vital organs and dispense drugs. Much bigger revenues can be generated if the clinic is a part of an organ transplant hospital. Foreign investment can be attracted to build and equip the hospital and foreign organ transplant specialists can be imported to staff the hospital. The host country can be a part owner or simply a rent and tax collector.

As yet, no countries have exploited this immense treasure chest of foreign exchanges. Is it due to a lack of entrepreneurship or is it the stigma that may be attached to a country as the "best place to die?" Certainly, there are enough cultures that celebrate final departures and would not mind the stigma.

THE HIGH COST OF DYING

The existing arrangements for final passages in the U.S. are extremely wasteful. Because dignified passages are illegal, an inordinate amount of resources are devoted to postponing final exits. In order to avoid malpractice suits, hospitals are reluctant to disconnect feeding tubes even with clear instructions to the contrary from hopelessly ill patients (Winslow, March 28, 1991: B7). Since third parties, *i.e.*, health insurance companies and Medicare, are picking up the tabs, aggressive treatments to postpone deaths are practiced regardless of benefits. It is estimated that 25-35% of Medicare expenditures in any given year go to 5-6% of those enrollees who will die within that year (Callahan, 1987: 130). Where non-aggressive long-term care is required, Medicaid picks up more than half of the nursing-home tabs of the elderly (Callahan, 1987: 157). Increased Medicaid funding of nursing-home care in turn leads to increased drain on Medicare as more nursing-home residents means more Medicare-funded treatments.ⁱ

Health-care costs for the hopelessly ill elderly are, of course, not limited to third-party funding. The out-of-pocket cost of health care to the older population tripled between 1977 and 1987, to 12.5% of its income (Ansberry, November 13, 1990: A1). Before the hopelessly-ill elderly are eligible for Medicaid funding of nursing-home care, they must spend down most of their life savings (Harley and Daniel, 1990: 22-23). For those who are not eligible for Medicare or Medicaid, they may even be forced to spend down their death savings. These death savings are the advance payments of death benefits from their life insurance policies. Such "living benefits" are increasingly available from life insurance companies that sell policies with "living benefits" riders, and from finance companies that buy the right to death benefits from the hopelessly ill for profit (Atchison, June 19, 1989: 79 and Dunn, February 19, 1990: 140).

Expenditures on postponing death of the hopelessly ill is inherently cost ineffective because the procedures are expensive but the quality of borrowed life so poor. Where long-term care is involved, \$75,000 to \$300,000 per person can be saved if care is shortened by five yearsⁱⁱ.

Because expenditures on postponing death cannot be reduced by dignified passage, they expand by squeezing out competing claims to third-party funding. For example, Medicaid funding of nursing-home care has squeezed out its funding for the non-elderly poor. Already, Medicaid financing of more than half of all nursing-home care of the elderly has reduced the share of Medicaid funding for the non-elderly poor (more than 90% of the total poor)

to only about 40% (Callahan, 1987: 151). The ballooning health-care expenditures for the elderly are largely a result of postponing death. Those over 65 years account for one third of the country's personal health-care expenditures even though they constitute only 12% of the total population (Ansberry, November 13, 1990: A1). And more Medicaid- and Medicare-funded treatments in turn lead to greater demand on Social Security as death is postponed.

A SCORCHED-EARTH POLICY

Where personal funding is involved, the U.S. federal government and states are actively promoting institutions and passing laws to facilitate the spending down of life and death savings. In the case of death savings, some state insurance commissioners are writing regulations to create a sellers' market for "living benefits" by setting minimum payments and encouraging competition (Dunn, February 19, 1990: 140). In the case of life savings, the Congress has passed laws to facilitate the tapping of home equity through reverse mortgages. In these mortgages, the bank sends the home owner a tax-free monthly check, instead of the other way around. Neither principal nor interest need be paid until the home owner dies and the home is sold. Reverse mortgages have not been popular with lenders because of the risk of property value decline and the absence of a secondary market for the mortgages. In 1988, the Federal Housing Administration started insuring reverse mortgages. And the Federal National Mortgage Association and the Federal Home Loan Mortgage Corp. have made a commitment to create a secondary market in FHA loans (Weinrobe, December 8, 1988: A16).

DYING FOR MONEY?

As long as dignified passage is illegal, we will never know for sure how many of the hopelessly ill who spend down their life and death savings and hang on to third-party funding do so because they want to extend their lives at all costs. By legalizing dignified passage, those who want to extend their lives at all costs could still do so. But those who want to reallocate their life and death savings for alternative uses are given a choice. In addition, their estate will be augmented by the converted benefits from their health insurance and Social Security. To remove the stigma of dying for money, a significant part of the converted death benefits could be earmarked for public charities onlyⁱⁱⁱ. The need to allocate these death benefits wisely for the public good will turn people into better informed citizens long before they become hopelessly ill. The deep-seated desire of every person to pass something valuable onto the next generation will make dignified passage all the more meaningful. Instead of the typical estrangement and isolation from the outside world experienced by the hopelessly ill, they will become the focus of attention and solicitation.

WHO SHOULD BE ELIGIBLE?

Since the purpose of dignified passage is to reduce needless suffering and conserve scarce resources, all hopelessly ill persons who have little chance of recovering to a state of minimal physical and/or financial independence should be eligible.

This eligibility criterion is broader than the physician-assisted death initiatives proposed and defeated in California and Washington, but close to Dr. Kevorkian's revealed criterion for choosing his medicide patients. Although limiting eligibility to terminal patients who have no more than six months to live may reduce political opposition, it does not reduce enough suffering or conserve enough resources. For example, one of four who are over 65 years and three out of five who are over 85 years need nursing-home care (Cahan and Pave, August 12, 1985: 78). Nursing-home residents can live for a long time functioning at an increasingly diminished capacity with no hope of regaining physical and/or financial independence. To exclude these patients is to put a band aid on a gaping wound. The unpopularity of Dr. Kevorkian's medicides among groups lobbying for physician-assisted death stems exactly from his extension of the eligibility boundary from the terminally ill to the hopelessly ill.

The advance of high-tech medicine has been made largely in converting the terminally ill into the hopelessly ill (Weisbrod, June 1991: 523-552). Unless the eligibility criterion is extended, the promise of voluntary death to reduce suffering and conserve resources will never be fulfilled. It is never clear whether the physician-assisted death initiatives were defeated because the opposition was too strong or the support was too weak. Extending the eligibility criterion may generate more support than opposition.

Provided that the same generally agreed upon procedural safeguards are observed and patient autonomy is respected, there is no reason why there would be more abuses just because the eligibility criterion is extended. Where the hopelessly ill is a minor, patient autonomy would be exercised by parents.

WHY BENEFIT CONVERSION?

If patients are self-insured, the amount of treatment will be determined by weighing the promise of recovery against the ability to pay. When the decision is against further aggressive treatment, dignified passage alone offers an attractive alternative to prolonged morbidity. There is no need for any compensation as an inducement because there are no common-pool benefits to be converted into private benefits. But when patients are insured, the insurer becomes a third party to the patient-physician relationship. Because the insurer usually cannot tell whether a treatment is motivated by actual need or by lower marginal cost of services to be insured, there is room for the insured and the service provider to use more services than would be used without insurance.

This *de facto* right to excessive treatment must be compensated if patients are to be induced to voluntarily choose dignified passage. This compensation consists of private benefits converted from projected common-pool resources required for futile treatment if dignified passage is not chosen.

Benefit conversion also gives volunteers a voice in determining how the saved resources should be re-deployed. For example, if a volunteer decides that the resources saved from futile treatment be used for pre-natal care, there is no surer way to do so than to give him the right to will it. Otherwise, the saved resources might instead be devoted to more futile treatments for those who should have chosen but refuse to choose dignified passage.

Finally, benefit conversion provides the dying with additional means for one final positive contribution to the community and his close relations.

A DUTY TO DIE?

Legalizing dignified passage no doubt offers a much needed alternative to futile treatments or prolonged morbidity. But may additional pressure to exercise this option come with this new freedom? Just as a right to vote implies a duty to vote, doesn't a right to die imply a duty to die?

It is doubtful that such pressure would increase with the availability of dignified passage and converted benefits, at least from close relations. Even without dignified passage, those hopelessly ill whose institutionalization is funded by third-party insurers impose very little physical hardship on their close relations. If these relations want to rid themselves of their residual caring duties, they have been free to do so by simply staying away. Those who choose to care for the hopelessly ill at home presumably do not mind the care-giving duties. Even without converted benefits, those who covet the estate of the hopelessly ill have been free to put pressure on them.

If there are indeed additional pressure from close relations, it can be easily diverted by appointing a power-of-attorney for health care and by assigning all estate and converted benefits to public charities.

In short, legalizing dignified passage would induce close relations to put pressure on the hopelessly ill only if the hopelessly ill are not insured by a third party. If anything, additional pressure is likely to come from the insurer. It is their bottom lines that are going to be improved when dignified passage is chosen. But unlike the more focussed private interests of close relations, third-party interests are more public and diffused. There are unlikely to be over-zealous agents going around pressuring the hopelessly ill.

Still, hopelessly ill patients are particularly vulnerable to covert or overt pressure from those who can benefit from their earlier death. And in spite of strict procedural safeguards, human frailty may still compromise them and lead to possible abuses. But these are not sufficient reasons for inaction as the world is full of slippery slopes (Fung, June 1998: 325-343).

CONCLUSIONS

The ability of high-tech medical advances to convert terminal illnesses into chronic and hopeless illnesses poses the most serious challenge to health-care cost containment. If futile attempts to prolong life are not resisted, no amount of health-care reform can be anything but stop-gap measures. But unless voluntary death can be easy and dignified, no hopelessly ill patients would choose them over futile treatment.

To the Chinese, the most venomous curse is that a person not die well. Unless we legalize dignified passage, the ability of modern medical technology to postpone death will ensure that this curse will come true for most of us.

REFERENCES

- Ansberry, Clare. "The Rising Prosperity of America's Retirees Is Unevenly Spread," *Wall Street Journal* (Nov. 13, 1990): A1.
- Atchison, Sandra D. "A Gift for the Dying - Or Sheer Ghoulishness?" *Business Week* (June 19, 1989): 79.
- Cahan, Vicky and Irene Pave. "The Big Boys of Insurance Move Into Nursing Home Care," *Business Week* (August 12, 1995): 78-79.
- Callahan, Daniel. *Setting Limits -- Medical Goal in An Aging Society* (New York: Simon & Schuster, 1987).
- Dunn, Don. "Putting More Life Into Death Benefits," *Business Week* (Feb. 19, 1990): 140.
- Fung, K. K. "On the Slippery Slope," *Journal of Economic Behavior and Organization* Vol. 9, No. 4 (June 1988): 325-343.
- Gordon, Harley. *How to Protect Your Life Savings From Catastrophic Illness and Nursing Homes*. (Boston, MA: Financial Planning Institute, Inc., 1990).
- Wasik, John F. "Can You Afford To Take Care of a Loved One," *Parade Magazine* (December 16, 1990): 12.
- Weinrobe, Maurice. "Liberating Home Equity of the Elderly Benefits All," *Wall Street Journal* (Dec. 8, 1988): A16.
- Weisbrod, Burton A. "The Health Care Quadrilemma: An Essay on Technological Change, Insurance, Quality of Care, and Cost Containment," *Journal of Economic Literature* Vol. 29 (June 1991): 523-552.
- Winslow, Ron. "Doctors and Nurses Are Said to Ignore Some Living Wills," *Wall Street Journal* (March 28, 1991): B7.

NOTES

- i. Medicare finances medical expenses for the elderly regardless of means but does not pay for nursing-home care except for a brief period in connection with medical treatments. Medicaid finances medical expenses for the poor regardless of age and pays for nursing-home care if the applicant is poor.
- ii. Long-term care costs range from an average of \$15,000 a year for home care to \$60,000 a year for a high-quality nursing-home care (Wasik, December 16, 1990: 12).
- iii. These public charities need not be confined to non-futile medical treatments such as pre-natal care. They can be schools, day-care centers, and libraries.