"Care in the last five years of life costs much more for patients with dementia than for those who die of heart disease, cancer, or other causes, a new study shows.

In addition to costing more across the board, out-of-pocket spending for patients with dementia is 81 percent higher than for people with other diseases. according to the study, conducted by the Icahn School of Medicine at Mount Sinai, Dartmouth College and University of California, Los Angeles and funded by the National Institute on Aging.

The burden is disproportionately high when the patients are black, have less than a high school education or are widowed or unmarried women, said the study, which looked at patient and family expenses as well as Medicare and Medicaid spending."

https://www.washingtonpost.com/local/social-issues/end-of-life-care-vastly-more-expensive-for-dementia-patients-than-for-others/2015/10/26/747dd8ee-7c15-11e5-beba-927fd8634498_story.html

At the peak of attention to health care models, before the Affordable Care Act came off its assembly line, colleagues and I published a proposal for a tiered model. We suggested that certain varieties of care -- both effective preventive services, and urgently needed treatments -- should be available to all with no financial barriers. A tier of services of slightly lesser value or need could be available to all, but might reasonably involve some barriers in the form of copays. Finally, a tier of quite discretionary services might come entirely out of our own pockets. This is one example of potentially rational rationing. [He thinks the value/need of a treatment is partly tied to the difference the treatment is likely to make to lifespan/welfare]

http://www.huffingtonpost.com/david-katz-md/health-care-rationing-the-roar-and-the-silence_b_7817194.html

Whose health care can be rationed? (parallel to "Who potentially has a duty to die?")

a. People who have lived a certain number of (good) years

b. People who have lived a certain percentage of the typical lifespan for people like them

c. People who are a burden to others

d. Anyone (as long as we maximize expected welfare)

1. If policy *x* maximizes expected utility, but distributes benefits/harms according to race/gender/religion/sexual preference, then it is morally wrong to have policy *x*.

2. If doing *x* maximizes expected utility, but distributes benefits/harms according to race/gender/religion/sexual preference, then there is no moral duty to do *x*.

Is there any non-discriminatory policy for rationing end-of-life care?

Is there a morally permissible way to ration end-of-life care?