

Meeting Needs and Respecting Persons: An Ethical Framework for the Allocation of Lifesaving Healthcare Interventions

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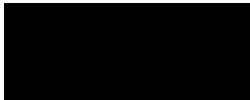
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No other person's work has been used without due acknowledgment in the main text of the thesis.

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Mr Xavier Symons



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Abstract

This thesis considers how we should allocate scarce, lifesaving healthcare interventions among persons in need. In some situations, clinicians must choose how to allocate scarce lifesaving interventions among their patients, and public health administrators must choose how to allocate scarce prophylaxis among population groups. Not everyone's needs can be met. It is apposite to consider, therefore, how the State should adjudicate between the competing claims that people make on healthcare resources.

In discussing this issue, I take as my point of departure the bioethical principle of respect for persons. Respect for persons is understood by many to be synonymous with the need to obtain informed consent from persons who receive medical treatment or participate in biomedical research. This thesis, however, advances an alternative account of respect based on an ethic of mutual accountability and a concern to take moral claims seriously (Darwall 2006). This conception of respect is used to develop a framework for rationing according to which we should base our decisions on the individual claims of need that candidates make on a resource, and allocate the resource to the person or group with the most serious and urgent health needs. I respond to several recent proposals arguing for the rationing of resources on the basis of age (Kamm 1998; Persad, Emanuel and Wertheimer 2008), utility (Miller 2008; Stein 2012), or desert (Segall 2011; Albertsen 2016). I argue that these approaches fail to take seriously the moral claim that other persons have on our assistance. We fail to respect persons if we fail to give appropriate consideration to their claims of need. This thesis concludes by providing general principles for the allocation of vital organs under conditions of scarcity, and the allocation of vaccines and treatment in a pandemic scenario.

Chapter 1: Introduction

This thesis considers how clinical and public health decision making should proceed given that healthcare resources – in particular, lifesaving healthcare resources – are scarce. In some situations, clinicians must choose how to allocate scarce lifesaving interventions among their patients, and public health administrators must choose how to allocate scarce prophylaxis among population groups.¹ Not everyone's needs can be met. The primary ethical question one must consider in these scenarios is “how should we allocate scarce lifesaving healthcare interventions among persons in need?”.

In recent decades, ethicists have argued that the State should ration lifesaving resources on the basis of utility,² age³ or desert.⁴ Many academic bioethicists believe that egalitarian criteria for allocation are ethically indefensible⁵ and lead to a wasteful use of resources.⁶ As such, it is suggested that we should employ alternative criteria that will maximise utility, prioritise

¹ I will presume it to be a fact that we have a discrete number of units of a lifesaving healthcare intervention. I will consider how, presuming that demand exceeds supply, we should allocate these units among a population.

² See, for example, Mark S. Stein. “A utilitarian approach to justice in health care”. In Rosamond Rhodes, Margaret Battin, Anita Silvers (eds.). *Medicine and Social Justice: Essays on the Distribution of Health Care*. New York: Oxford University Press, 2012: 47-56; Mark A. Miller *et al.* “Prioritization of influenza pandemic vaccination to minimize years of life lost”. *The Journal of Infectious Diseases* 198;3 (2008): 305–311.

³ See, for example, Govind Persad, Allan Wertheimer, Ezekiel Emanuel. “Principles for allocation of scarce medical interventions”. *The Lancet* 373 (2009):423-431; Frances Kamm. *Morality, Mortality. Volume I: Death and Whom to Save From It?* Oxford: Oxford University Press, 1998: 234 -236.

⁴ See, for example, Walter Glannon. “Responsibility, alcoholism, and liver transplantation”. *The Journal of Medicine and Philosophy* 23;1 (1998): 31–49; Andres Albertsen. “Drinking in the last chance saloon: luck egalitarianism, alcohol consumption, and the organ transplant waiting list”. *Medicine, Health Care and Philosophy* 19;2 (2016): 325–338.

⁵ Persad, Wertheimer and Emanuel 2009, 429.

⁶ Alena Buyx *et al.* “Ethics and effectiveness: rationing healthcare by thresholds of minimum effectiveness”. *British Medical Journal* 342 (2011): 54; Howard Brody. “From an ethics of rationing to an ethics of waste avoidance”. *New England Journal of Medicine* 366;21 (2012): 1949-1951.

younger persons, or ensure that those who are responsible for their illness receive lesser priority.

This thesis rejects these proposals. Rather, it is argued that *respect for persons* should be the orienting principle of our framework for lifesaving resource allocation. Respect for persons is an idea that has a diverse philosophical pedigree. For the purposes of this thesis, however, I will use the term to denote the idea that persons *qua* moral agents have a special value and deserve to be taken seriously in matters of distribution.⁷ Specifically, our allocation decisions should take seriously the claims made by each individual. We should not aggregate claims (an idea that will be discussed in detail in chapter four), nor should we seek to equalise lifetime levels of access to healthcare (an idea that will be discussed in chapter five). Rather, in situations where multiple persons have a claim on a scarce resource, the State should give priority to the person who has the most serious and urgent health needs. Health need, I contend, is at the centre of the claims that persons make on lifesaving healthcare resources.⁸ This – rather than utility, age, equality or desert – is the appropriate criterion with which to ration lifesaving interventions.

An objective and reliable measure is, nevertheless, required to assess the strength of each person's claim of need. In this thesis I will expound a detailed conception of health need, and will argue that this account constitutes an objective and practicable standard with which to assess the claims that persons or groups make for lifesaving medical care. This conception of health need focuses primarily on the severity of a patient's condition and the urgency with

⁷ Stephen Darwall. "Two kinds of respect". *Ethics* 88;1 (1977): 36-49.

⁸ Related to this, some commentators have outlined a specific category of moral claims which they call *claims of need*. These claims focus primarily on an impending harm faced by an agent should they not receive a needed object. See David Wiggins. "Claims of need". In *Needs, Values, Truth* (3rd ed.) Oxford: Oxford University Press: 1998: 1–57; Sarah Clark Miller. *The Ethics of Need: Agency, Dignity, and Obligation*. London: Routledge, 2013.

which they require treatment or prophylaxis. Crucially, my account of need eschews a utilitarian focus on capacity to benefit. I will argue that we respect persons when allocating lifesaving resources by considering the severity and urgency of their health needs rather than their capacity to benefit.

This introduction will briefly outline the parameters of discussion, and will also offer a precis of the argumentation in each of subsequent chapters. I will offer a definition of human health, and will define the notion of lifesaving healthcare resources. I will also distinguish between State-controlled resources and resources in the control of private vendors. In the thesis precis, I will discuss the motivation behind the ethical frameworks and real-world case studies that I have chosen to focus on.

1. Health, health needs, and lifesaving healthcare interventions

It is necessary at the outset of this thesis to define human health.⁹ While there is much debate about how we should define the concept,¹⁰ for the purposes of this thesis I will adopt a *normal functioning range* conception of human health. According to this view, human health is defined in terms of a series of indices of normal functioning, such as measures for normal circulation, respiration, digestion, metabolism, mobility and immunity. One may also include more complex functions such as social interaction, emotional regulation and the ability to regulate impulses responsible for the avoidance of (for example) addictive behaviour. Health shortfall – a concept that will be discussed at length in chapter three – refers to deviations from the

⁹ For a detailed discussion of the relationship between the definition of disease and justice, see Thomas Schramme. "The significance of the concept of disease for justice in health care". *Theoretical Medicine and Bioethics* 28;2 (2007): 121-135.

¹⁰ Dominic Murphy. "Concepts of disease and health". In Edward N. Zalta (ed.). *The Stanford Encyclopedia of Philosophy* (Spring 2015). Stanford: Stanford Metaphysics Lab, 2015. Available from <https://plato.stanford.edu/entries/health-disease/>.

normal functioning range of human beings in terms of the indices of human health. Persons who fall outside of the normal functioning range for human beings of their age and sex can be said to be experiencing a health shortfall.¹¹

Health need is a concept that has often been invoked in discussions about resource allocation.¹² Importantly, health need is not a binary concept. Rather, health needs can be graded along different axes – in particular, the axes of severity and urgency.¹³ In chapter three, I will argue that health needs are the sorts of things that we can make objective judgements about and use to distinguish persons vying for scarce resources.

This thesis is focused in particular on the distribution of *lifesaving healthcare resources*. By lifesaving healthcare resources, I have in mind resources that postpone death for a period of time that is deemed to be both morally and medically significant.¹⁴ Admittedly, there is no such thing as a resource that preserves someone’s life indefinitely. As Hope *et al* write, “none of us, however, is immortal and all any healthcare intervention can do is postpone death (or extend life)”.¹⁵ There are, however, resources that offer a significant extension of life expectancy for people who would otherwise face death. For example, a heart transplant may add several

¹¹ Cf. Efrat Ram-Tiktin. “Basic human functional capacities as the currency of sufficientarian distribution in health care”. In Carina Fourie and Annette Rid (eds.). *What is Enough?: Sufficiency, Justice, and Health*. Oxford University Press, 2016: 144-163.

¹² See, for example, Allan S. Brett. “Physicians have a responsibility to meet the healthcare needs of society”. *Journal of Medical Ethics* 40;3 (2012): 526-531.

¹³ Tony Hope, Lars Osterdal, Andreas Hasman. “An inquiry into the principles of needs-based allocation of health care”. *Bioethics* 24;9 (2010): 470-480; 472.

¹⁴ For a critique of the idea of ‘life saving’ treatment, see Richard Yetter-Chappell. “Against ‘saving lives’: equal concern and differential impact”. *Bioethics* 30;3 2016: 159–164.

¹⁵ Hope *et al.* 2010, 474.

more years to the life expectancy of someone with end stage heart failure. It is resources of this kind that I will be concerned with.¹⁶

2. State-controlled resources versus resources controlled by private vendors

In this thesis, I will focus specifically on healthcare resources that are in the control of the State. That is, I will focus on those resources that governments and healthcare authorities have the responsibility to distribute. One example would be organs distributed through a State-run organ transplantation registry. Organ transplantation in most western nations is coordinated by a central, State-run service. Another example would be a government stockpile of influenza vaccines. Developed countries around the world have stockpiled millions of doses of various vaccines in anticipation of the possibility of a viral pandemic. Demand for vaccine in a pandemic may, however, exceed supply, and so it is necessary for states to develop protocols for vaccine distribution among the general population.

State-run resource allocation programs differ from private services that provide lifesaving treatment or prophylaxis. The moral obligations of a private vendor differ from those of the State. Private vendors do not necessarily have a responsibility to meet the health needs of members of society.¹⁷ The State, in contrast, has a responsibility to meet the needs of the citizenry, at least when conditions are favourable.¹⁸ Furthermore, there is a plausible argument to suggest that the State should adopt an egalitarian approach when distributing resources.

¹⁶ For the sake of simplicity, I will focus specifically on *indivisible resources*, i.e., resources that cannot be divided among persons. For a discussion of the difference between indivisible and divisible resources, see Richard Galvin and Charles Lockhart. "Discrete idiosyncratic goods and structural principles of distributive justice". *The Journal of Politics* 52;4 (1990): 1182-1204.

¹⁷ Robert Nozick. *Anarchy, State, and Utopia*. New York: Basic Books, 1974: 233-235.

¹⁸ David Copp. "Equality, justice, and the basic needs". In: Gillian Brock (ed.) *Necessary Goods: Our Responsibilities to Meet Others' Needs*. New York: Rowman & Littlefield Publishers, 1998: 113-134.

That is, it should not unduly privilege one individual or group over another, but rather must treat different candidates for receiving a resource in an equal manner. As Harris writes,

“...the State has a basic obligation, *inter alia*, to treat all citizens as equals in the distribution of benefits and opportunities which affect their civil rights... The civil rights generated by this principle will of course include rights to the allocation of such things as legal protections and educational and health care resources”.¹⁹

The State, according to Harris, exists among other things to treat all citizens as equals in the distribution of benefits and opportunities. It should discharge this duty in a way that “treat[s] each citizen as the equal of any other”.²⁰ One must, of course, clarify what it means to treat citizens equally, and this topic will be discussed at length in the subsequent chapters of this thesis. But the basic argument stands, namely, that the State should not unduly privilege one candidate for a resource over another but rather should adopt an egalitarian approach to distribution.

3. Thesis precis

This thesis takes as its point of departure a discussion of the bioethical principle of respect for persons. Chapter two outlines how an ethic of respect for persons provides guidance for the allocation of lifesaving healthcare interventions. Two conceptions of respect for persons are considered – one that pertains to the autonomous decisions of persons, and another that concerns the capacity of persons to make moral claims. The implications of these two conceptions of respect are discussed. The chapter also considers what it means to take claims seriously. It is argued that a criterion of need should be employed to assess the strength of individual claims.

¹⁹ Harris 1987, 121.

²⁰ Harris 1987, 121.

Chapter three considers the different ways in which a criterion of need can be operationalised. It argues that the most plausible interpretation of a criterion of need is one in which we give priority to the worst off. The chapter then analyses three dimensions of health need – health shortfall, urgency, and capacity to benefit. It is argued that health shortfall and urgency should be the two main axes against which we measure the strength of people’s claims. The latter sections of the chapter consider how a criterion of need applies to the allocation of life saving healthcare interventions. Specifically, the chapter outlines a decision-procedure for situations where we are dealing with patients with equivalent health needs. It is argued that the mechanism of patient selection should be impartial – that is, it should not leave any one patient at inherent disadvantage. A lottery mechanism is endorsed, as well as a waiting list and first come, first served policy.

The next three chapters of the thesis deal with alternative approaches to the rationing of lifesaving healthcare interventions. Chapter four critically evaluates utilitarian approaches to the rationing of lifesaving interventions. Three varieties of utilitarian rationing are discussed – a save-the-most-lives approach; rationing on the basis of QALYs or life years saved; and rationing on the basis of social utility. Proponents of these approaches argue that their frameworks ensure an efficient allocation of resources. Utilitarian approaches to rationing, however, maximise utility at the expense of respecting persons. They fail to take seriously the claim that each person has on our assistance, and ration resources instead with a view to maximising benefits.

Utilitarian practical ethicists often argue in favour of age-based rationing on the basis that it maximises the benefit gained from scarce healthcare resources. There is, nevertheless, another line of argumentation that is used to justify age-based rationing. This is the claim that fairness requires of us that we prioritise younger persons over older persons. Theorists argue that older persons have had their fair share of relevant equalisanda (such as resources and

opportunities), and that we should now prioritise the lives and needs of younger persons. Chapter five critically evaluates these arguments. It discusses some common objections made to egalitarian defences of age-based rationing. I argue that even fairness-based arguments in favour of age-based rationing are in tension with respect for the moral standing of persons. Rather than considering a person's needs-over-a-lifetime, the State should ration care based on people's current claims of need.

Chapter six discusses responsibility-sensitive criteria for allocation, situating these criteria in the context of so-called *luck egalitarian* theories of distributive justice. It offers an overview of how a responsibility-sensitive criterion might be operationalised in healthcare resource allocation. The chapter also raises a series of objections to the application of a responsibility criterion to the allocation of scarce indivisible healthcare resources. It is argued that we should not deprive people of basic healthcare, even if they are personally responsible for their illness. Responsibility-based criteria also fail to take into account the nuances of the notion of personal responsibility, such as the fact that many of our health-related choices are heavily influenced by socio-economic factors. The chapter argues that we have reason to resist the use of a responsibility criterion for rationing, even as a tie-breaker in situations where we are dealing with individuals with equivalent health needs.

Chapter seven and chapter eight discuss two practical scenarios in which we must ration lifesaving healthcare resources. These are, namely, the allocation of vital organs under conditions of scarcity, and the allocation of vaccines in a pandemic scenario. Chapter seven discusses extant organ allocation protocols, and considers how a criterion of need would apply to the rationing of organs. It also critically evaluates proposals to ration organs on the basis of capacity to benefit, age, or responsibility for illness. Chapter eight considers how the State should ration vaccines and treatment in an influenza pandemic. It rejects recent proposals to ration vaccines on the basis of life years saved or likelihood of survival. It also considers

whether persons providing essential services such as frontline healthcare staff should receive priority access to vaccine.

Importantly, there is a voluminous literature on the ethics of organ allocation as well as the rationing of vaccine in a pandemic. Organ allocation has been the subject of a number of famous thought experiments in moral philosophy,²¹ and has also generated extensive debate in academic bioethics.²² Many bioethicists have also discussed the ethics of vaccine allocation in a pandemic scenario.²³ In addition to the burgeoning literature on these topics, organ allocation and rationing in a pandemic also allow us to explore in practical contexts some of the theoretical issues raised in the early stages of this thesis. It is instructive to consider whether organs should be rationed on the basis of age, utility, or candidates' responsibility for their own illness. It is also useful to consider whether vaccines should be allocated to the persons most likely to survive a pandemic, or whether this intervention should be given first to those who have the highest risk of morbidity and mortality if infected.

This thesis concludes with a reflection on how a framework of respect for persons and a criterion of need would apply to other healthcare resource allocation scenarios. The relationship between normative theory and policy is considered. I close by arguing for a radical change of emphasis in contemporary literature on healthcare resource allocation – away from criteria focusing on utility, age or desert, and toward an ethic of respect for persons.

²¹ Philippa Foot. "The problem of abortion and the doctrine of double effect". In *Virtues and Vices: And Other Essays in Moral Philosophy*. London: Oxford University Press, 2002: 19-34; 23; John Harris. "The survival lottery". *Philosophy* 50 (1975): 81-87.

²² For a comprehensive overview of the ethical issues surrounding organ allocation, see Robert Veatch, Lainie Ross. *Transplantation Ethics* (2nd ed.). Washington DC: Georgetown University Press, 2015.

²³ For an overview of the ethics of vaccine allocation in a pandemic scenario, see Keymanthri Moodley *et al.* "Ethical considerations for vaccination programs in acute humanitarian emergencies". *Bulletin of the World Health Organisation* 91 (2013): 290-297.

To reiterate, respect for persons is a foundational principle in both research ethics and clinical ethics.²⁴ The principle, however, is often defined narrowly as a precept that pertains to the autonomy of patients and research participants.²⁵ In this thesis I aim to offer a more expansive account of respect persons that can illuminate the obligations that we have to claimants when distributing scarce healthcare resources. It is to this task that we now turn.

²⁴ Mary Catherine Beach *et al.* "What does 'respect' mean? Exploring the moral obligation of health professionals to respect patients". *Journal of General Internal Medicine* 22;5 (2007): 692-695; Johan Brannmark. "Respect for persons in bioethics: towards a human rights-based account". *Human Rights Review* 18;2 (2017): 171-187.

²⁵ See, for example, Ruth Macklin. "Applying the four principles". *Journal of Medical Ethics* 29 (2003): 275-280.

Chapter 2: Respect for persons and taking claims seriously

Many ethicists would contend that we should respect persons when we distribute resources.¹ Yet it is unclear what this means in practice. For some, the idea of respect for persons is synonymous with the idea of respect for autonomy.² We respect persons, on this view, by ensuring that persons can direct their lives in accord with some overall plan that they have reflectively endorsed. In practice, this means that we must always obtain consent from persons where they are the subject of a medical intervention or a participant in biomedical research. This conception of respect, nevertheless, provides little guidance for the distribution of resources, as consent is a peripheral issue in resource allocation.³ Rather, the fundamental issue we are considering is how we should allocate resources when we cannot meet everyone's needs.

This chapter presents an alternative account of respect for persons. Specifically, I will discuss a conception of respect that focuses on the second-personal competence of practical reasoners to engage in moral discourse with one another. We respect persons, on this alternative view, by acknowledging the authority of other persons to make moral claims on us and to be themselves the subject of moral claims. This account of respect is broader than the dominant interpretation of respect for persons in contemporary bioethics discourse.⁴ Unlike a

¹ See, for example, John Harris. "QALYfying the value of life". *Journal of Medical Ethics* 13 (1987): 117-123; 120; Martha Nussbaum. *Frontiers of Justice: Disability, Nationality, Species Membership*. Cambridge: Harvard University Press, 2006: 92; Greg Bognar, Samuel Kerstein. "Saving lives and respecting persons". *Journal of Ethics and Social Philosophy* 5;2 (2010): 1-20.

² M. Therese Lysaught. "Respect: or, how respect for persons became respect for autonomy". *Journal of Medicine and Philosophy* 29;6 (2004): 665-680.

³ It matters, of course, whether people actually choose to make a claim on a scarce resource. Sometimes people may choose to forgo a lifesaving intervention.

⁴ Cf. O. Carter Snead, Kelly Mulder-Westrate. "Autonomy and individual responsibility". In: Henk Ten Have, Bert Gordijn (eds.). *Handbook of Global Bioethics*. Dordrecht: Springer, 2014: 75-83.

paradigm of respect focused on autonomy, this account provides guidance for the decision-procedure that we should adopt when distributing lifesaving healthcare resources. Specifically, it requires that we respect the individual claims that persons have on the resources in our control.

The first section of this chapter discusses two justifications that theorists have provided for the idea of respect for persons. One justification focuses on autonomy, while the other focuses on an ethic of accountability. The implications of these two conceptions of respect for persons are considered. Respect for autonomy requires, principally, that clinicians and researchers obtain informed consent from patients and research participants. Respect for the moral authority of persons, in contrast, requires that we take seriously the reasonable demands that other moral agents make on us. In the context of resource allocation, this account of respect means that clinicians and healthcare administrators should seek to satisfy the individual claims of need that people make on healthcare resources. The second section of this chapter discusses what it means to *take claims seriously*. I argue against a strict egalitarian approach to evaluating competing claims, suggesting rather that we should assess the relative strength of claims based on objective criteria. To this end, this chapter considers how a criterion of need provides us with an objective standard against which to measure the competing claims that persons make on lifesaving healthcare resources.

1. Respect for persons: two perspectives

Proponents of an ethic of respect for persons assert that persons are morally special in the universe.⁵ In light of this, persons are said to deserve consideration in our deliberation about

⁵ Cf. William Frankena. "The ethics of respect for persons". *Philosophical Topics* 14;2 (1986): 149-167; 150.

what we morally ought to do.⁶ This section offers a brief overview of the philosophical justification for claiming that persons have special moral worth. Importantly, the justification that theorists give for *why* we should respect persons has direct implications for *how* we think we should respect persons. This section distinguishes two broad approaches to justifying the idea of respect for persons – one that focuses on autonomy, and one that focuses on the capacity of persons to make moral claims. The implications of these two interpretations of respect are considered.

1.1: Autonomy as the basis of respect for persons

Many theorists link respect for persons specifically to autonomy. We respect persons, on this view, by respecting the considered decisions that persons make about how they will live their lives. Human beings, unlike other animals, have the capacity to direct their lives in accord with a particular plan that they have reflectively endorsed. The thought is that the capacity of human persons to direct the course of their own lives distinguishes them from other creatures and makes them worthy of special regard.⁷

A justification for this view is found in Immanuel Kant's account of the relationship between human dignity and morality. Kant argued that what gives dignity or worth to persons is their capacity for moral self-governance. Thus, in the *Groundwork to the Metaphysics of Morals*, he wrote:

“...morality is the condition under which alone a rational being can be an end in itself, since only through this is it possible to be a law-giving member in the kingdom of ends.

⁶ Ibid.

⁷ See, for example, Jeff McMahan. *The Ethics of Killing: Problems at the Margins of Life*. New York: Oxford University Press, 2002: 256.

Hence morality, and humanity insofar as it is capable of morality, is that which alone has dignity”.⁸

Human beings have dignity, then, on account of their capacity for moral cognition or practical rationality. They are worthy of respect insofar as they are rational and capable of moral self-determination, or of knowing and acting in accord with the universal moral law.⁹ Importantly, Kant is here referring to autonomy as constrained by the ordinances of practical reason. This is different from the conception of ‘autonomy’ advanced in the work of philosophers such Robert Nozick.¹⁰ This grasp of morality distinguishes human beings from other creatures in the universe who are of a non-rational nature.¹¹

Christine Korsgaard builds upon this idea in her book *The Sources of Normativity*. Korsgaard argues that moral obligation is grounded in agents’ first-personal reflective endorsement of their own practical identities (for example, one’s identity as a mother, lover, friend or student or egoist). Our various practical identities give rise to specific moral duties. A prerequisite for endorsing any practical identity, however, is a reflective endorsement of our own humanity. Humanity – our identity as reflective animals who need reasons to act – is the basis of our reflective endorsement of more specific, practical identities. Thus, Korsgaard writes:

“... th[e] reason for conforming to your particular practical identities is...a reason that springs from your humanity itself, from your identity simply as a human being, a reflective animal who needs reasons to act and to live. And so it is a reason you have

⁸ Immanuel Kant. *Groundwork to the Metaphysics of Morals* Mary Gregor (ed.). London: Cambridge University Press, 1996: 42.

⁹ Cf. *Ibid.*, 43: “autonomy is therefore the ground of the dignity of human nature and of every rational nature”.

¹⁰ For Nozick, autonomy refers to the “ability to form a picture of one’s whole life (or at least of significant chunks of it) and to act in terms of some overall conception of the life one wishes to lead”. See Robert Nozick. *Anarchy, State, Utopia*. New York: Basic Books, 1974: 50.

¹¹ Allan W. Wood. “Kant on duties regarding nonrational nature”. *Aristotelian Society Supplementary Volume* 72; 1 (1998): 189-210.

only if you treat humanity as a practical, normative, form of identity, that is, if you value yourself as a human being”.¹²

Korsgaard adopts a Kantian conception of autonomy and argues that beings act freely when they act “on a maxim which we could will to be a law”.¹³ The thought is that we act freely only when we act on the basis of reasons that can be universalised (i.e., function as a universal rule for action). In endorsing the value of our own humanity, then, we commit to humanity being valued universally, not only in ourselves but also in others.¹⁴ This, for Korsgaard, is the basis of respect for humanity as it is manifest in our own person or in the person of others.

In the context of biomedical practice, the principle of respect for persons has in recent decades been associated with the requirement to obtain informed consent from patients and research participants.¹⁵ Tom Beauchamp and James Childress, for example, assert that respect for autonomy is a basic normative principle of bioethics. They argue that this principle finds support both in Kant’s account of persons as autonomous moral agents, and Mill’s view that persons ought to be allowed to develop their own individual identity unimpeded by the interference of other individuals or the State.¹⁶ Respect for autonomy, according to Beauchamp and Childress, entails “acknowledging [the] decision-making rights” of patients and “enabling persons to act autonomously”.¹⁷ This idea can be framed in terms of a negative obligation – that “autonomous actions should not be subjected to the controlling constraints of

¹² Christine M. Korsgaard. *The Sources of Normativity*. New York: Cambridge University Press, 1996: 121.

¹³ *Ibid.*, 98.

¹⁴ *Ibid.*, 121.

¹⁵ James Wilson. “Is respect for autonomy defensible?”. *Journal of Medical Ethics* 33 (2007):353–356; 353-354.

¹⁶ Tom Beauchamp, James Childress. *Principles of Biomedical Ethics* (5th ed.). London: Oxford University Press, 2001: 63-64.

¹⁷ *Ibid.*, 63.

others” – as well as the positive obligation – to “disclos[e] information and foster[...] autonomous decision-making”.¹⁸

The principle of respect for autonomy requires that persons be allowed to choose which treatment option they wish to pursue, or whether or not they wish to participate in research.¹⁹ These decisions should be respected. Clinicians and researchers should refrain from placing any undue influence on patients or research participants as they make these decisions. This kind of respect is sometimes described as a “constraint” on biomedical practice.²⁰ While medicine and related disciplines should aim at improving health and increasing scientific knowledge, the pursuit of these goals should not come at the expense of failing to obtain consent from patients or research participants.

Respect for autonomy also has implications for the manner in which contracts with patients and research participants are made and maintained. Clinicians and researchers should, for example, respect patient privacy and the protection of confidential information.²¹ The thought is that we respect a person’s autonomy by respecting the conditions under which they consented to treatment or research. As John O’Brien and Cyril Chantler state, “autonomy encompasses not just the right to self-determination about our bodies and how they are treated, but also to information about ourselves, our lifestyles, and our health”.²² Patient consent would be invalidated if clinicians and researchers violated the contractual agreements made with patients. Furthermore, respect for autonomy requires that the risks and benefits of

¹⁸ Beauchamp and Childress 2001, 64.

¹⁹ Ibid., 64-65.

²⁰ James Childress. “The place of autonomy in bioethics”. *The Hastings Centre Report* 20;1 (1990): 12-17; 16.

²¹ Beauchamp and Childress 2001, 65.

²² John O’Brien, Cyril Chantler. “Confidentiality and the duties of care”. *Journal of Medical Ethics* 29 (2003): 36-40; 26.

treatment are fully disclosed to patients and research participants. A person cannot make an informed decision without having access to all the relevant information about what will be done to them.

While respect for autonomy provides guidance on issues such as the nature and importance of informed consent, it does not provide guidance for the allocation of scarce resources. Resource allocation dilemmas involve people who have competing claims on resources. The principle of respect for autonomy, however, is silent on the question of whether and under what circumstances patients are entitled to access scarce resources. If anything, it seems that an autonomy-based view could be used to justify a range of conflicting procedures for choosing between persons who stand to lose their lives.²³ Theorists have, therefore, invoked other values, such as justice, utility, equality and beneficence to provide concrete guidance for determining how we should allocate resources.²⁴

To be clear, I am not arguing that respect for autonomy conflicts with ethical frameworks for healthcare rationing. Rather, my claim is that the current understanding of respect for persons in bioethics is limited and does not provide guidance for resource allocation. If we believe that respect for persons *should* guide our distribution of resources, we must look for an alternative account of what it means to respect persons. I therefore will now consider an alternative conception of respect for persons grounded in an ethic of mutual accountability.²⁵

1.2: Mutual accountability as the basis of respect for persons

²³ Greg Bognar, Samuel Kerstein. "Saving lives and respecting persons". *Journal of Ethics and Social Philosophy* 5;2 (2010): 3-7.

²⁴ See, for example, the pluralist approach in Beachamp and Childress 2001, 250-272.

²⁵ Cf. Joel Feinberg. "The nature and value of rights". *The Journal of Value Inquiry* 4 (1970): 245-257; 252.

Several contemporary moral theorists have critically engaged with Kant in developing their own account of what it means to respect persons. One example is Stephen Darwall. Darwall rejects the classical Kantian view that morality is grounded in a first-personal exercise of moral agency. Rather, Darwall bases his moral theory on an analysis of the *second-personal* moral discourse that takes place between persons. He argues that all of morality is in fact second-personal in character, and that we should focus on the second-personal interactions of moral agents to make sense of ideas such as respect and obligation.²⁶ In this section, I will argue that we can gain significant insight into how we can resolve resource allocation dilemmas through a consideration of Darwall's account of respect for persons.

Kant argued that persons are deserving of respect because practical reason requires that we respect humanity as it is present in other people.²⁷ For Darwall, however, respect goes beyond a moral imperative generated by practical reason. Rather, the concept of respect for persons is grounded in the fact that persons have "the authority to make claims and demands on one another as free and rational agents".²⁸ Persons are deserving of respect not merely because they are free and rational beings. Rather, persons are deserving of respect because they have the capacity to *demand* respect from us. This is, in fact, what Darwall understands by the idea of personhood. "[To] be a person", Darwall writes, "just is to have the authority to address demands as a person to other persons, and to be addressed by them, within a community of

²⁶ Stephen Darwall. *The Second Person Standpoint: Morality, Respect, and Accountability*. Cambridge: Harvard University Press, 2006: Ch. 5.

²⁷ According to Kant, persons have a dignity that is beyond all price. This dignity is grounded in their status as free and rational beings. See Kant 1996, 42.

²⁸ Stephen Darwall. "Respect and the second-person standpoint". *Proceedings and Addresses of the American Philosophical Association* 78;2 (Nov., 2004): 43-59; 43.

mutually accountable equals”.²⁹ Persons are defined, then, by their capacity to engage in second-personal moral discourse.

We respect persons by acknowledging their authority to address us as moral equals. We should acknowledge the authority of persons to make moral claims on us, as well as to be the subject of moral claims. Hence Darwall writes:

“respect for persons is a responsiveness to what someone can claim by virtue of being an agent with second-personal competence”.³⁰

Kant’s account of respect for persons is expressed in precepts such as the Formula of Humanity, according to which we should refrain from using persons merely as a means and not also as an end.³¹ But Darwall’s account of respect focuses in particular on the claims that persons *qua* moral equals make on each other. Respect does not just involve a prohibition on the instrumentalisation of persons, but also requires that we respond appropriately to the specific content of the claims that other persons make on us.

Darwall suggests that this account of respect has very specific implications for the manner in which we discharge our duties to others. Specifically, we should fulfill our moral duties *in a way that preserves the moral agency of others*. Darwall writes:

“Respect for others thus involves making oneself accountable to others as equal persons, rather than simply taking account of any fact, norm, or value about one another as persons in our own private deliberations”.³²

²⁹ Ibid., 51.

³⁰ Darwall 2006, 127.

³¹ Kant 1996, 429.

³² Darwall 2006, 137.

When we discharge our duties to others, we should recognise the “legitimate claim” that they have on our doing so.³³ The reasons why we should respect persons are not confined to maxims that we apprehend in our own private moral deliberations. Rather, we should also recognise the second-personal authority of persons to demand respect. Darwall writes that “the dignity of persons includes a second-personal authority to address demands for compliance with the first-order duties of respect”.³⁴ He repeatedly quotes John Rawls’ statement that persons are “self-originating sources of valid claims”.³⁵ In this sense, we should respect people in a way that recognises their moral authority to demand respect from us.³⁶ Darwall does not provide a detailed account of what this kind of respect would look like in practice, but presumably it would require that we explicitly acknowledge in some way the moral authority of the agent who is making a claim on our respect. It also plausibly requires of us that we ensure that our principles for action are principles that other moral agents can be reasonably expected to accept.

Importantly, Darwall argues that we owe persons respect *whether they explicitly request this of us or not*. The norms of respect for persons, he suggests, are “in force” in our moral community, and these norms should govern conduct independent of whether they are explicitly stated by persons. He writes,

“...it takes neither an explicit actual demand nor a demand that is implicit in actual human beings prone to make it, either individually or collectively, in order for a claim

³³ Ibid.

³⁴ Ibid.

³⁵ John Rawls. “Kantian constructivism in moral theory”. *The Journal of Philosophy* 77;9 (1980): 515-572; 546.

³⁶ Ibid.

or demand to be in force. The demand is made by the “moral community” and by all of us insofar as we are members”.³⁷

By *moral community*, Darwall is referring to a “regulative ideal” based on what moral agents *qua* free and equal would agree as being the norms that should regulate our interactions with each other. A *moral community* is not just an association that people form where they have a shared interest in the project of morality. Rather, the term *moral community* also denotes the set of moral and behavioural norms that should govern the interaction of mutually accountable practical reasoners.

So far we have only made passing reference the specific content of Darwall’s account of respect for persons. Interestingly, Darwall does not commit to a substantive theory of morality, but instead notes that his framework has a special affinity with contractualism. Thus, he writes:

“I believe that a second-personal framework has a special affinity to a contractualist account of moral obligation...answerability to one another is written in to the foundations of contractualism as an expression of equal respect”.³⁸

The thought here is that Darwall’s account of the foundations of morality overlap with the fundamental tenets of a contractualist account of moral obligation. Like contractualist moral theorists, Darwall suggests that morality (or, at least, the domain of morality that concerns what people owe to each other) is grounded in the mutual accountability of practical reasoners. The content of morality just is the set of principles for governing behaviour that all moral agents can be reasonably expected to accept. Darwall does not go further than this in expounding his account of moral obligation, aside from noting that his framework would be compatible with both a Rawlsian and Scanlonian account of moral obligation.³⁹

³⁷ Stephen Darwall. “Reply to Korsgaard, Wallace, and Watson”. *Ethics* 118;1 (2007):52-69; 65.

³⁸ Darwall 2007, 65.

³⁹ Darwall 2007, 65.

I do not wish to delve too deeply into Darwall's account of morality, as this would take us beyond the scope of this thesis. Rather, the aim of this section is to consider how his account of respect for persons can inform our approach to the allocation of scarce healthcare resources, and it is to this task that I now turn.

To recap, Darwall gives an account of respect for persons in terms of the mutual accountability practical reasoners inherit from the second-personal stance, a stance framed in neo-contractualist terms and with an emphasis on the moral equality implied by the demands addressed to all those belonging to the moral community. For our purposes, we can appropriate this idea, namely, that respect for persons is predicated on the relationships of mutual accountability that exist between moral agents. Rather than viewing respect solely in terms of personal autonomy, Darwall provides us with a framework for thinking about respect in terms of a recognition of the moral authority of others to make claims on our assistance.

We should not, however, only attend to the explicit claims that persons make on our respect. We should also attend to the claims that are "in force" in our moral community (whether or not someone has explicitly given voice to them). That is, we should not just be concerned with what people actually demand of us, but also with the norms that govern a community of mutually accountable practical reasoners. As Darwall notes, demands "[are] made by the "moral community" and by all of us insofar as we are members".⁴⁰ The collective voice of the moral community issues forth in a series of general demands that we apprehend when thinking about how we ought to interact with others. We should, then, recognise both the explicit claims that persons make on our respect and the implicit norms that are in force in our moral community.

⁴⁰ Darwall 2007, 65.

Drawing upon these ideas, we can now consider the implications of an ethic of mutual accountability for the resolution of resource allocation dilemmas. The allocation of resources by the State might be thought to be a domain of ethics that is distinct from ethical issues pertaining to what persons owe to one another.⁴¹ If we view the distribution of resources through the lens of an ethic of mutual respect, however, we gain insight into the obligations that we have when responding to the competing claims that people make on the resources in our control.

One practical implication is that we should respect the moral authority of persons who make claims on healthcare resources. Where persons make a claim on the goods in our control, we should give due consideration to that claim. We dignify a person by taking their claim into account.⁴² We disrespect persons, in contrast, by ignoring their claim or by failing to make ourselves accountable to them as our moral equals. As Darwall writes,

“Even in a case where one has no genuine claim except to make a request or a plea, if someone to whom one addresses the request refuses even to give one a hearing, this too is a kind of disrespect”.⁴³

In practice, then, we should seek to respond appropriately to the claims that persons make on our assistance – even where those claims are, in the last analysis, defeated by other moral considerations.

This, in turn, has implications for the ethical considerations that inform our decisions about resource allocation. Many theorists, as we shall see, argue that we should aggregate claims

⁴¹ Cf. Fred Dycus Miller. *Nature, Justice and Rights in Aristotle's Politics*. London: Oxford University Press, 1997: 70-74.

⁴² Cf. Sarah Clark Miller. “Reconsidering dignity relationally”. *Ethics and Social Welfare* 11;2 (2017): 108-121.

⁴³ Darwall 2006, 60.

when deciding how we will distribute scarce resources. Such an approach seeks to maximise the good produced by our distribution of resources by combining the claims of individuals together into group claims. Yet the framework of mutual accountability that we have adopted requires that we give individual consideration to the claims that each person has on resources in our control. An ethic of mutual accountability blocks aggregative considerations in our decision procedure. Rather, we should consider how each individual claim or complaint compares to every other individual claim or complaint, and we should act based on principles that each individual can be reasonably expected to accept.⁴⁴

Furthermore, we should take into account the fact that there are claims “in force” that are implied by an ethic of mutual accountability, even if not explicitly stated. Importantly, in healthcare resource allocation, it is often the case that we are approaching problems from the perspective of a public health administrator who must make decisions affecting very large numbers of persons. In some situations (particularly macro-level resource allocation scenarios) it is not possible to consider the claim that each individual has made on a resource. Rather, in these situations, we should rely on a consideration of the claims that are “in force” in our moral community. We should consider how the norms of a community of mutually accountable practical reasoners might inform our macro-level decisions about healthcare resource distribution.⁴⁵ In doing this, we can anticipate the claims that persons *would make* on the resources in our control – even if, in the real world, there is an epistemic barrier to the individual consideration of claims.

To be clear, my claim is that the norms of the moral community provide a guide to what persons could reasonably claim of State in matters of distribution. We can, for example, read

⁴⁴ John Taurek. “Should the numbers count?”. *Philosophy & Public Affairs* 6;4 (1977): 293-316; 294.

⁴⁵ Kristen Baeroe. “Public health ethics: resource allocation and the ethics of legitimacy”. *Journal of Clinical Research & Bioethics* 4 (2011): 1-3.

off from the norms of the moral community what it would be acceptable for a person to demand from healthcare authorities in times of scarcity. This can function as a guide for how we should distribute resources where there is an epistemic barrier to the individual consideration of claims. It may be the case that, in practice, a person chooses to forgo their claim on healthcare resources, or makes a claim that appeals to considerations of utility, age or desert. Yet if we cannot consider claims individually, this approach to distribution functions as a practicable means to respect persons when allocating resources at a macro-level. In any case, I will argue that individual claims based on utility, age or desert conflict with an ethic of respect for persons and, therefore, should not inform our resource allocation decisions.

It may also be the case that we are dealing with patients who are physically incapable of making a claim on a resource. We may, for example, be dealing with patients who are in a comatose state and yet are in need of life support. In such cases, it is not necessary for a patient to make an explicit claim on a resource to be considered eligible for access to that resource. We should, rather, consider the claims which are in force in the moral community when deciding whether these persons should receive the resource in question. Non-competent persons such as persons in a comatose state plausibly still form part of our moral community.⁴⁶ Our interactions with them, then, should be informed by the norms that govern interaction between mutually accountable practical reasoners.⁴⁷

It is important to consider what sorts of claims persons have the authority to make in the context of a public healthcare system. So far we have considered the general obligations that obtain between persons *qua* moral equals. Yet plausibly, our understanding of what is a reasonable or legitimate demand should also be informed by the context-specific authority of

⁴⁶ Shelly Kagan. "What's wrong with speciesism?". *Journal of Applied Philosophy* 33;1 (2016): 1-21.

⁴⁷ P.F. Strawson. "Freedom and resentment". *Proceedings of the British Academy* 48 (1962): 1–25.

a moral agent, and the circumstances under which the claim is made. Social norms of respect and decorum, for example, are based on what is appropriate in specific situations. What is fitting and just in one situation may not be fitting and just in a different situation. Darwall, furthermore, uses examples that are context specific – such as a sergeant commanding a platoon – to explain his account of second-personal moral authority.⁴⁸ The thought is that the moral authority of the sergeant gives legitimacy to the claims that he makes on his troops. It stands to reason, then, that our conception of what counts as a legitimate claim should be informed by relevant contextual factors.

For our purposes, we can consider what respect for persons looks like in the context of a public healthcare system. The *raison d'être* of a public healthcare system is to meet the health needs of a population.⁴⁹ Patients, then, have a claim on healthcare simply by virtue of the fact that they are sick or injured. Insofar as they have non-trivial health needs, patients can legitimately demand that they receive medical assistance to alleviate their illness or injury. This is certainly true of patients who are so ill that they are in need of a lifesaving healthcare intervention.

Granted, our understanding of what is a reasonable demand will also be conditioned by the availability of appropriate resources, and the other claims that have been made on our assistance. A patient does not necessarily have the authority to demand immediate medical attention. The strength of their claim on care will depend on their health needs and who else is making a claim on care. In the next section, I will discuss how we should go about making decisions between patients with competing claims on a resource. Yet the basic point remains, namely, that our distributive decisions should be based on the legitimate claims that people

⁴⁸ Darwall 2006, 12-13.

⁴⁹ Cf. Bernard Williams. "The idea of equality". In Peter Laslett & W. G. Runciman (Eds.). *Philosophy, Politics, and Society*. Oxford: Basil Blackwell, 1963: 110-131.

make on the resources in our control (even if we attach differing strength to people's claims based on contextual factors). In the case of healthcare, people have a claim on our assistance when they are ill. Our distribution of resources should be responsive to these claims.

Our approach to resource allocation, in summary, should be one in which we make ourselves accountable to the persons with a claim on the resources in our control. The principles that we employ to resolve these dilemmas should be based on what is acceptable to the reasonable agents vying for healthcare resources. Furthermore, we should consider how each individual claim compares to every other individual claim, rather than aggregating individual claims into group claims. Much of contemporary ethics relies on an agent-neutral approach to ethical deliberation, or alternatively the perspective of a self stripped of any prior ethical or social commitments. Yet the ethical framework I have just proposed requires that we adopt a context specific, second-personal perspective when deliberating about how to allocate resources.

In the remainder of this thesis, I will focus on a conception of respect that is based on the moral authority that persons have to make claims on each other. As stated, an autonomy-based view of respect is silent on the ethics of resource allocation, as access to healthcare is an issue of entitlement rather than consent.⁵⁰ Yet insofar as we recognise the authority of persons to make claims on our assistance, then we cannot overlook the legitimate claims that persons make on the resources in our control.

⁵⁰ My claim is that it does not intuitively follow from a conception of the moral significance of autonomy that persons have an entitlement to healthcare. One must develop a substantive account of the link between autonomy and access to healthcare, or alternatively one must invoke alternative principles to justify a claim about entitlement to healthcare. For a related discussion, see Bognar and Kerstein 2010, 3-7.

It might be objected that this framework is not applicable to distributive concerns that arise in the domain of public health. Public health is about promoting the health of populations, yet the framework I have proposed focuses on the claims of individuals. It could be argued that public health initiatives should focus on the maximisation of health-related welfare rather than being concerned with individual claims of need.⁵¹

Yet there need not always conflict between the goals of public healthcare initiatives and an ethic of respect for persons. While the approach that I have been advocating places constraints on aggregation, it still allows for the pursuit of population health and wellbeing. The only requirement is that we do not disregard our obligations to individuals when pursuing optimal collective health outcomes.⁵² Public health administrators should consider the claims that are “in force” in a community when allocating resources across a population. In the later chapters of this thesis, I will consider how we can respect persons in the allocation of prophylaxis among a population.

An interlocutor may argue that this side-constraint on distribution will seriously impede the promotion of population health. Addressing individual claims of need could distract us from the core business of public health – to promote the health-related wellbeing of whole populations. We might, for example, consider the example of providing prophylaxis for vulnerable populations during an influenza pandemic. The time and resources required to vaccinate vulnerable populations may negatively impact upon our ability to provide vaccine to

⁵¹ Alex Rajczi. “Liberalism and public health ethics”. *Bioethics* 30;2 (2016): 96-108.

⁵² Cf. Madison Powers, Ruth Faden, Yashar Saghai. “Liberty, Mill, and the framework of public health ethics”. *Public Health Ethics* 5;1 (2012): 6-15; Angus Dawson, Bruce Jennings. “The place of solidarity in public health ethics”. *Public Health Reviews* 34;1 (2012): 65-79; Michael Keane. Public health interventions need to meet the same standards of medical ethics and individual health interventions”. *The American Journal of Bioethics* 10;3 (2010): 36-38.

the general population. As such, the requirement that we should respect persons may conflict with the goal of maximising population health.

Yet my claim is not that there will never be a conflict between the goals of public health and an ethic of respect for persons. I concede that in some cases an ethic of respect for persons will require that we revise existing allocation protocols for resources such as vaccines. Yet there are also many points of overlapping consensus between a framework that seeks to maximise population health and a framework that seeks to respect persons. Indeed, in a later chapter on vaccination I will argue that the goal of maximising the number of lives saved often overlaps with a concern to meet the needs of the worst off.

2. Taking claims seriously

We have just considered a conception of respect that focuses on the moral authority of persons *qua* our moral equals. Yet there is a need to clarify what it means in practice to take people's claims *seriously*. We must specify what in practice it means to recognise the moral authority of persons *qua* our moral equals. We must also consider what we should do when we are dealing with competing claims made by agents on a resource.

One approach is to argue that we should give *equal weight* to all claims. Some theorists argue that we should not make judgements about the relative strength of claims as such judgements will be dependent upon controversial value commitments. Instead, we should give equal consideration to all claims, provided that each claim has at least some justification. Moral claims, on this understanding, are said to have the same intrinsic worth regardless of their content. Thus, in an essay on the distribution of healthcare resources, John Harris has written that:

“[a] fair method of distribution [is] one that does not *de jure* or *de facto* treat some patients, some rival claimants for care, as more valuable or more important than others”.⁵³

Harris argues that factors such as the capacity to benefit of patients is irrelevant to determining the strength of their claim. All that matters is that persons have *some justification* for making a claim on a resource.

Yet many disagree with this view.⁵⁴ Treating claims as if they were equivalent does not do justice to the uniqueness of individual moral claims. Moral claims are of such a character that they have greater or lesser strength depending on their content. When persons address moral claims to us, then, we should not respond in a generic way, as if claims were completely indistinguishable. Rather, we should attend to the specific content of each claim, and prioritise those persons who have the strongest claim on resources. This is what it really means to take claims seriously, and to make ourselves accountable to others.

It is useful here to consider the difference between claims and absolute rights.⁵⁵ Claims are of such a character that they can be stronger or weaker depending on the justification that one yields for making a claim. A claim is, ultimately, a case that someone has for receiving something. And one’s case can be stronger or weaker depending on the evidence that one can provide to justify one’s case. This contrasts with absolute rights, which, as Joel Feinberg writes, do not differ in strength:

⁵³ John Harris. “What is the good of health care”. *Bioethics* 10;4 (1996): 269-291; 290.

⁵⁴ See, for example, Daniel Sulmasy. “Speaking of the value of life”. *Kennedy Institute of Ethics Journal* 21;2 (2011): 181-199.

⁵⁵ I am here drawing upon a distinction between absolute rights and pro tanto rights. Absolute rights can never be infringed, whereas pro tanto rights may be permissibly be infringed in some circumstances. There is a debate in the literature on rights about whether some rights are absolute, or whether all rights are pro tanto rights. I set this debate to one side, and presume for argument’s sake that absolute rights exist. See Danny Frederick. “Pro-tanto versus absolute rights”. *Philosophical Forum* 45;4 (2014): 375-394.

“Rights...do not differ in degree: no one right is more of a right than another”.⁵⁶

When someone has an absolute right to something, that right should be satisfied. Claims, in contrast, need not always be satisfied. While claims deserve “a fair hearing and consideration”,⁵⁷ it may be the case that we deem one claim to be of greater importance than another claim. We may decide that other claims deserve priority over a claim that we are currently considering. Claims constitute a reason for action that may or may not be defeated by other countervailing reasons.

The problem with the view that theorists like Harris advance is that they seem to presume that each candidate has an *absolute right* to the resource being distributed. Yet in reality each candidate only has a claim on the resource.⁵⁸ What we are trying to establish in ethical discourse about allocation is which candidate has the strongest claim on the resource. It would be mistaken to presume that a candidate’s right to a resource has already been established. Rather, we should set about assessing the strength of the case that each candidate makes for receiving the distribuendum. We should assess the specific content of the claims being made.

Indeed, if we presumed that each individual has an absolute right to the resource, then further ethical discussion would be in vain. The only question to discuss would be how we should go about distributing resources in a way that somehow did not violate the rights of those in need of the resource. And even then, it is unclear whether any outcome could possibly avoid violating the rights of those who do not actually end receiving the resource. John Broome describes claims as “duties owed” to persons, and attempts to justify a lottery procedure for

⁵⁶ Feinberg 1970, 622.

⁵⁷ Feinberg 1970, 254.

⁵⁸ Cf. Leonard Fleck. “Health care rationing, terminal illness, and the medically least well off”. *The Journal of Law, Medicine and Ethics* 39;2 (2011): 156-171; 156.

distribution in terms of the surrogate satisfaction of our duties to persons.⁵⁹ Yet as we shall discuss in chapter three, a lottery does not provide any satisfaction at all for persons. We are left then, without a mode of distribution that respects the rights of all claimants. This provides further justification for distinguishing claims from rights.

We should, then, seek to prioritise people's claims based on their relative strength.⁶⁰ Yet the question that arises from this view is, namely, "how should we assess the relative strength of the claims of persons?". We have argued that some claims present themselves as being stronger than others. Yet we have not yet identified the basis on which such judgements can be made. Furthermore, respect requires that we make ourselves accountable to the claims that each person makes on us. And we must also be wary of ignoring weaker claims and only focusing on stronger claims.

An interlocutor might argue that an ethic of respect for persons is too demanding. It requires that we consider every single claim made on a resource. Yet it is impracticable to give full consideration to a claim that each individual makes on a scarce resource when we are dealing with large numbers of persons in institutional contexts.⁶¹ Rather, we should adopt a more practicable approach to resource allocation – one which seeks to maximise utility or eliminate inequality.

Yet I would argue that we *can* make ourselves accountable to each individual who makes a claim on our assistance. The claims that are made in the context of healthcare resource allocation are based primarily on need. People make claims on healthcare resources based

⁵⁹ John Broome. "Fairness". *Proceedings of the Aristotelian Society* 91 (1990): 87-101; 92.

⁶⁰ Stephen Darwall. "Two kinds of respect". *Ethics* 88;1 (1977): 36-49; 38.

⁶¹ For discussion of the trade-off between empathy and efficiency in real world healthcare settings, see Angeliki Kerasidou. "Empathy and efficiency in healthcare at times of austerity". *Health Care Analysis* (2019): DOI: <https://doi.org/10.1007/s10728-019-00373-x>.

on the health needs that they have. For this reason, a *principle of need* becomes of central importance to our investigation. In the next section, I will argue that a principle of need provides an objective and operationalisable measure for adjudicating between the competing claims that people make on resources. It also satisfies the requirements of an ethic of mutual accountability, for need is a criterion that is drawn from the essential content of the claims that people make on healthcare resources. It is the claimants themselves, then, who give the rule to our decision procedure for resource allocation. While we may not be able to consider each claim individually, we can make ourselves accountable to claimants by basing our decisions on a metric that they implicitly endorse.

3. A criterion of need as an objective standard for ranking claims

The concept of need has received significant attention in discussions about distributive justice. Specifically, it has been argued that needs can function as a defensible criterion for distribution of resources. While contemporary theorists have variously described the currency of distributive justice as capabilities,⁶² welfare,⁶³ opportunity,⁶⁴ and luck,⁶⁵ there are several scholars who argue that the satisfaction of basic needs should be given lexical priority in our distributive decisions.⁶⁶ In this section, I will outline how need provides us with an objective and ethically defensible standard against which to measure the competing claims that persons make on resources.

⁶² Amartya Sen. "Equality of what?". In John Rawls, Sterling M. McMurrin (eds.). *Liberty, Equality, and Law: Selected Tanner Lectures on Moral Philosophy*. Salt Lake City: University of Utah Press, 1987: 198-220.

⁶³ Richard J. Arneson. "Welfare should be the currency of justice". *Canadian Journal of Philosophy* 30;4 (2000): 497-524.

⁶⁴ John Rawls. *A Theory of Justice*. Cambridge: Harvard University Press, 1971.

⁶⁵ Carl Knight. "Luck egalitarianism". *Philosophy Compass* 8;10 (2013): 924-934.

⁶⁶ See, for example, Soren Reader. *The Philosophy of Need*. London: Cambridge University Press, 2006.

Several theorists have defined the concept of basic needs in terms of the preconditions for human beings to participate in social life and pursue their conception of the good.⁶⁷ Basic needs, on this view, are the necessary conditions that must be met for someone to be able to live a life that is distinctively human. They differ from other needs insofar as they are irreducible to some more primitive exigency of human life. Len Doyal, for example, suggests that physical survival and personal autonomy are the most basic human needs. She writes:

“For individuals to act and to be responsible, they must have both the physical and mental capacity to do so—at the very least a body that is alive and that is governed by all of the relevant causal processes and the mental competence to deliberate and to choose...Since physical survival and personal autonomy are the preconditions for any individual action in any culture, they constitute the most basic human needs”.⁶⁸

The intuition motivating this account of basic needs, then, is that human beings are unable to pursue goals and participate in community life if they lack physical health or the capacity to make autonomous decisions.

It would take us too far afield to defend an account of basic human needs, though I am sympathetic to Doyal’s account. Suffice to say that *health need* should feature in any robust account of basic human needs. Health is a *sine qua non* for human beings to survive and act in the world. The other needs that are ubiquitous on lists of basic human needs presuppose a minimum degree of health.⁶⁹ Without a basic level of health, people cannot engage in social

⁶⁷ For an introduction to the literature on basic needs, see Gillian Brock. “Needs and distributive justice”. In Gerald F. Gaus, and Fred D’Agostino (eds.). *The Routledge Companion to Social and Political Philosophy*. London: Routledge, 2012: 444-455.

⁶⁸ Len Doyal. “A theory of human need”. In Gillian Brock (ed.). *Necessary Goods: Our Responsibility to Meet Others Needs*. London: Rowman and Littlefield, 1998: 157-172; 158-159.

⁶⁹ See, for example, David Baybrooke. *Meeting Needs*. Princeton: Princeton University Press, 1987: 60-80.

life and participate in those activities that we take to be characteristic of distinctly human existence. Health, therefore, is a necessity if human beings are to live a life that is characteristic of their nature.

For the purposes of this thesis, then, I will assume that health is a basic human need. In the remainder of this chapter, I will make a series of observations that indicate how need provides us with an objective standard against which to measure competing claims. Specifically, needs are an objective and useful measure as they are mind-independent, non-binary, and amenable to scientific measurement. Need is, furthermore, an essential part of the claims that persons make on resources. A criterion of need, then, satisfies the requirements of an ethic of mutual accountability, for it is drawn from the essential content of the claims that persons make on resources. In this way, we recognise in our decision procedure our accountability to others as our fellow moral agents.

First, needs are mind-independent.⁷⁰ To say that someone needs *x* is not to say that that person has a mental state of needing *x*. Rather, needs refer to facts about the world, and, specifically, facts about a person's body or social situation. Needs, in this sense, cannot be altered by changes in the way that we think. Desires or wants, in contrast, are mental states, and can change depending on our psychology. Desires and wants refer to pro-attitudes that we have toward objects, goods, or states of affairs. Importantly, while desires and wants may be about things in the world, they can change depending on the way that we think. My desires and wants can change depending on a variety of subjective factors. They are mind-dependent in a way that needs are not.

⁷⁰ Tony Hope, Lars Osterdal, Andreas Hausman. "An inquiry into the principles of needs-based allocation of healthcare". *Bioethics* 24;9 (2010): 470-480.

Second, needs are *graded*.⁷¹ There are a range of factors that can increase or lessen one's need of an object, good or state of affairs. One's level of need can be greater or lesser depending on the gravity of the harm that one faces should their need go unmet. Someone who needs something to avoid death can be said to have a dire need of that thing. Needs are also more serious in situations where someone needs something with *urgency*. Someone who needs something immediately to avoid harm can be said to need that thing with great urgency. Furthermore, one's needs can be said to be more serious in situations where there is no possible alternative to satisfying one's needs.⁷² By this I mean that there is no other way for someone to avoid harm than by obtaining a particular object or good or bringing about a particular state of affairs. In the next chapter, I will discuss the different axes against which we can measure the relative strength of people's health needs.

Third, we can use sciences such as medicine and economics to measure needs with reliability and precision. This point has been illustrated by the work of Len Doyal and Ian Gough – two theorists whose pioneering work on the concept of need sparked philosophical discussion of the term. Doyal and Gough start with a philosophical claim about the two preconditions that enable non-impaired participation in any form of life.⁷³ These are, namely, physical health and the capacity for rational choice or autonomy. From this philosophical assertion, the authors look to the social sciences for guidance about what sorts of human needs must be met if people are to in practice preserve health and engage in free and rational activity. They provide a list of “intermediate needs” that answer to the human need for health and the capacity for rational activity. Importantly, these intermediate needs – such as the need for nutritious food and clean water, appropriate health care and education – are things that can be subject to

⁷¹ David Wiggins. “Claims of need”. In *Needs, Values, Truth: Essays in the Philosophy of Value* (3rd ed.). London: Oxford University Press, 2002: 1-58; 14-15.

⁷² Hope, Osterdal, Hausman 2010, 472.

⁷³ Len Doyal, Ian Gough. *A Theory of Human Need*. London: MacMillan Press, 1991: Ch.4.

measurement using validated tools from biomedical and social sciences. We can, in this sense, provide reasonably precise measurements of the degree to which someone is in need of something. In the next chapter, we will consider specifically how different indices from medical practice can be used to measure health need.

This is not to deny the importance of moral philosophical analysis when evaluating the importance of meeting needs. As Chad Horne has observed, “we cannot offload difficult questions about what we owe to each other onto medical science”.⁷⁴ Rather, it is necessary to provide a philosophical justification as to why need matters, and why differences in need matter. The next chapter will provide a philosophically robust account of what it means to have a health need. There are multiple ways in which the idea of health need can be understood. I will consider what role concepts such as severity, urgency, capacity to benefit and probability should play in a conception of health need. I will also consider what role these concepts should play in determining who morally speaking we should prioritise.

Finally, need is a criterion that is appropriately related to the claims that people make on resources. We are not using an arbitrary criterion like hair colour or height to assess the strength of a person’s claims. Rather, the claims that people make on healthcare resources are *claims of need*. The primary justification that people give for their claim on a resource is their need for that resource.⁷⁵ If someone lacked a need for a healthcare resource, there would be no meaningful sense in which they could lay claim to it. In this sense, need is an objective measure that is *internal* to the claims that people make on resources. One cannot be accused of failing to take claims seriously by employing a criterion of need. Rather, this criterion allows

⁷⁴ L. Chad Horne. “Medical need, equality, and uncertainty”. *Bioethics* 30;8 (2016): 588-596; 589. See also Donna Dickenson. “Can medical criteria settle the need priority setting debates? The need for ethical analysis”. *Health Care Analysis* 7;2 (1999): 131-137.

⁷⁵ Cf. Wiggins 2002, 4-6.

us to adjudicate between claims using a standard drawn from the very content of the claims themselves.

Moral claims are not confined to claims of need. As Peter Stone observes, “there are many possible bases for making claims—need, merit, desert, contribution, and so on, or some combination of several factors”.⁷⁶ Yet I will argue in the later chapters that claims on healthcare based on utility, desert, or age should *not* be considered, as they are incompatible with respect for persons. Essentially, claims based on utility, desert or age presuppose that the claim that persons have on access to healthcare is dependent on factors other than one’s moral status as a person and one’s objective level of need. This conflicts with the idea that persons have moral authority by virtue of the fact that they have the capacity to make claims. The moral authority of persons to make claims on us – at least when they are in situations of basic need – is not dependent on circumstantial factors. Rather, it is based on the capacity of persons for interpersonal moral discourse.

There is good justification, then, for using a standard of need to distinguish between claimants vying for healthcare resources. The question we set out to answer at the end of the last section was, namely, “how should we assess the relative strength of the claims of persons?”. I have provided some indication of how a criterion of need might be operationalised in the context of resource allocation. I will argue in the next chapter that a standard of health need allows us to rank the needs of persons based on the severity of their illness and the urgency with which they require treatment.

A criterion of need is useful when we are dealing with claims of different strength. It may, however, sometimes be the case that people have equivalent needs, and, therefore, have

⁷⁶ Peter Stone. “Why lotteries are just”. *The Journal of Political Philosophy* 15;3 (2007) 276–295; 278.

claims of equivalent strength. In such cases, we will need to move to a meta-level of decision making to resolve the impasse. A criterion of need indicates that we are dealing with persons with claims of equivalent strength, and for this reason, allocation procedures such as a lottery become relevant to our moral deliberations. We need an additional decision method to resolve the tie.

Conclusion

In this chapter I have introduced a conception of respect for persons that differs significantly from the concept of respect for persons implicit in contemporary bioethics discourse. Rather than focusing on informed consent, I have focused on the importance of acknowledging the moral authority of others to make moral claims on us. In practice, this means that we should give due consideration to the claims that persons make on the resources in our control. In the latter sections of this chapter, I discussed what specifically it means to *take moral claims seriously*. I argued that a criterion of need provides us with an objective, impartial and relevant measure with which to distinguish the strength of the claims of different candidates vying for a resource.

In the next chapter, I will consider specifically how we should understand the concept of health need. I will discuss what role concepts such as urgency, severity, capacity to benefit and probability should play in our assessment of people's relative levels of need. I will also consider what criteria we should employ in situations where we are dealing with candidates with equivalent needs. I will argue that the procedural norms governing distribution should reflect the fact that candidates have equivalent needs. People should be given an equal chance of accessing a resource where they have an equally strong claim on that resource.

Chapter 3: Respect for persons, need, and the allocation of lifesaving healthcare resources

One practical implication of an ethic of respect for persons is that we should take the claims of persons seriously when we are distributing resources. The previous chapter argued that scarce resources should be allocated to the person or group with the strongest claim of need. This chapter outlines how a philosophically robust conception of health need can be used to evaluate the strength of the claims that persons have on lifesaving medical care. This chapter also considers how resources should be allocated when candidates have claims of equal strength. It discusses how the moral authority of claimants can be respected through impartial allocation procedures such as a lottery.

Importantly, it is not immediately apparent how a criterion of need provides guidance for situations where we cannot satisfy everyone's claims. There are several, mutually exclusive interpretations of a criterion of need that have been advanced in the literature.¹ One can prioritise those persons who have the greatest capacity to benefit;² one can prioritise those patients who are closer to being restored to full health;³ or one can prioritise those patients who are worst off (or sickest).⁴ All of these approaches are arguably compatible with prioritisation on the basis of need, for they constitute different ways of responding to claims of

¹ Drew Carter, Jason Gordon, Amber Watt. "Competing principles for allocating healthcare resources". *Journal of Medicine and Philosophy* 41;5 (2016): 558-583.

² Alan Williams. "Ethics and efficiency in the provision of health care". *Royal Institute of Philosophy Supplements* 23 (1998): 111-126.

³ Andreas Hasman, Tony Hope, Lars Osterdal. "Health care need: three interpretations". *Journal of Applied Philosophy* 23;2 (2006): 145-156.

⁴ Niklas Juth. "Challenges for a principle of need in health care". *Health Care Analysis* 23 (2015): 78-79.

need of persons who are sick or injured. As such, it is necessary to make a judgement about how we shall interpret a criterion of need.

The first section of this chapter considers which of these applications of a criterion of need is most compatible with the *raison d'être* of need as a distributive principle. I argue that a principle of need is best interpreted as tracking the severity of the illness or injury of a person or group (i.e., it tracks illness or injury rather than capacity to benefit from treatment).⁵ I then offer an account of what it means to be *worst off* with respect to health. I discuss the role that health shortfall, urgency and capacity to benefit play in determining need.⁶ I also consider how such a criterion applies to the allocation of lifesaving healthcare interventions. The final section of this chapter considers how we should allocate treatment in situations where patients have equivalent needs. The mechanism of patient selection, I argue, should be impartial, and should not leave anyone at a disadvantage. I defend the use of a lottery mechanism and first come, first served policy for healthcare rationing.

1. Interpreting a criterion of need

Many theorists argue for the application of a criterion of need to the distribution of healthcare.⁷ Yet as Niklas Juth states, “although the principle of need [...] enjoys such wide support, it is unclear what it actually says and what it entails in practice...”.⁸ Theorists offer different and

⁵ Capacity to benefit does play some role in determining need, but only as a minimum threshold that someone must meet to classify as having a need.

⁶ Allen Andrew Alvarez. “The cross-cultural importance of satisfying basic needs”. *Bioethics* 23;9 (2009): 486-496; Anders Herlitz. “Indeterminacy and a principle of need”. *Theoretical Medicine and Bioethics* 38;1 (2017): 1-14.

⁷ See, for example, Norman Daniels. *Just Health: Meeting Health Needs Fairly*. London: Cambridge, 2008; Michael Walzer. *Spheres of Justice: A Defense of Pluralism and Equality*. New York: Basic Books, 1983: 86-91; Bernard Williams. “The idea of equality”. In Peter Laslett & W. G. Runciman (eds.). *Philosophy, Politics, and Society*. Oxford: Basil Blackwell, 1963: 110-131.

⁸ Juth 2015, 74.

sometimes conflicting accounts of what it means to be in need. It is necessary, then, to identify what is the most plausible interpretation of a principle of need, as we require a way of determining which person or persons have the strongest claim on lifesaving resources. We require a clear account of the meaning of the term *need* that can provide guidance for how we should allocate lifesaving resources among patients who are very ill. In this section I will discuss three interpretations of need: need as capacity to benefit, need as capacity to be returned to species typical functioning, and need as poor state of health. I will argue that the last of these is the most plausible interpretation of need as a distributive principle in healthcare.

Some theorists define need in terms of a patient's capacity to benefit from treatment. That is, health needs are said to be determined by a patient's capacity to experience health-related gains from an intervention.⁹ Alan Williams, for example, argued that

“the most plausible interpretation of what people intend to convey in the health care context by appealing to the notion of need is that someone would be better off *with* the ‘needed’ treatment than *without* it”.¹⁰

Williams notes that there are different ways in which we can define the idea of benefit, and the kinds of benefits we deem to be significant will differ depending on the intervention being administered.¹¹ But setting these nuances to one side, the basic thought is that a patient's level of need is determined by the degree to which they stand to benefit from treatment.

This interpretation of need is compatible with utilitarian moral theory, as a focus on capacity to benefit ensures that we obtain maximal utility from healthcare resources. The patients who

⁹ Hasman, Hope and Osterdal 2006, 150.

¹⁰ Alan Williams. “Ethics and efficiency in the provision of health care”. *Royal Institute of Philosophy Supplements* 23 (1988): 111-126; 117.

¹¹ Ibid.. See also Alan Williams, “Need as a demand concept (with special reference to health)”. In AJ Culyer (ed.). *Economic Policies and Social Goals*. London: Martin Robertson, 1974: 60-76.

receive treatments will be those who have the greatest capacity to benefit and therefore are considered to be *most in need*. Plausibly, we should not waste scarce lifesaving resources on someone who has little capacity to benefit. We should, rather, adopt a framework that is sensitive to the “relative benefit” to be had by candidates.¹² Furthermore, the notion of *medically indicated treatment* is based on how much a patient stands to gain from receiving an intervention. As such, there is a clinical precedent for thinking about need for treatment in terms of capacity to benefit.¹³

A related interpretation of need is one that defines need in terms of species typical functioning.¹⁴ A need, on this view, is something that is required by a person to restore them to (or maintain) species typical functioning. The main aim of healthcare is to restore people to health, and so one might reasonably infer that needs should be defined in terms of normal human functioning. Norman Daniels adopts a variant of this view, writing that:

“. . . health care needs will be those things we need in order to maintain, restore or provide functional equivalents (where possible) to, normal species functioning”.¹⁵

On this view, a patient can be said to be in need of a healthcare intervention if that intervention will take them “from a state below the normal functioning range into the normal functioning range”.¹⁶

¹² Mark S. Stein. “A utilitarian approach to justice in health care”. In Rosamond Rhodes, Margaret Battin, and Anita Silvers (eds.). *Medicine and Social Justice: Essays on the Distribution of Health Care*. New York: Oxford University Press, 2012: 47-56; 49.

¹³ Philip Rosoff. *Drawing the Line: Healthcare Rationing and the Cutoff Problem*. New York: Oxford University Press, 2016: 79-86.

¹⁴ Cf. Tony Hope, Lars Peter Osterdal, Andreas Hasman. “An inquiry into the principles of needs-based allocation of health care”. *Bioethics* 24;9 (2010): 470-480; 473.

¹⁵ Norman Daniels, “Health care needs and distributive justice”. *Philosophy & Public Affairs*. 10;2 (1981): 146–179; 158.

¹⁶ Hope, Osterdal and Hasman 2010, 473.

Like a conception of need as capacity to benefit, this view would ensure an efficient use of resources. The patients who are considered to be in need, on this account, are those and only those who have a realistic possibility of being restored to species typical functioning. These patients would be considered to have the strongest claim on healthcare resources. To provide a concrete example, we can consider an intervention that enables someone previously bed-bound to move around. In this case, the patients most in need will be those persons who are capable of recovering their mobility. We should prioritise these patients over other patients who are not capable of recovering movement – the latter are unable to return to a state of normal human functioning, at least in the domain of mobility.

An alternative approach would be one that defines need in terms of the state of health of patients. In particular, we could define need in terms of the sickness that a patient is experiencing. On this approach, the neediest patient would be the patient who is in the worst state of health.¹⁷ There is, of course, a need to specify what it means to be worst off with respect to health. The basic contrast, nevertheless, is manifest: rather than defining need relative to one's ability to benefit from an intervention, this approach defines need in terms of how bad one's state of health is.

Importantly, this approach would lead to significantly different outcomes to a framework based on capacity to benefit, as those patients who are sickest will not necessarily (not even typically) be the patients with the greatest capacity to benefit. In many situations the severity of a person's illness or injury is negatively correlated with their ability to benefit from treatment. Yet the sickest patients would still be considered *most in need*, and would be given priority.

¹⁷ Mathias Barra *et al.* "Severity as a priority setting criterion: setting a challenging research agenda". *Health Care Analysis* 2019: 1-20.

The ethos of a criterion of need is, I would argue, best reflected in an approach that gives priority to those patients who are worst off or sickest. Importantly, while needs-based distributive frameworks differ significantly, all give some “normative importance to those persons who are badly-off”.¹⁸ That is, all distributive frameworks focused on need hold that the fact that someone is badly-off should make a difference in matters of distribution. In fact, scholars such as Gustavsson and Juth suggest that:

“The normative core of principles of need [is] the moral intuition that concern for the worst off ought to be taken seriously”.¹⁹

A view that defines ‘need’ in terms of illness or injury, then, is most reflective of the meaning given to the term by theorists who invoke the concept in debates about distribution. Furthermore, the idea of need is typically related to necessity, or the idea that someone requires something to avoid serious harm.²⁰ Insofar as this is the case, then it stands to reason that a criterion of need should be understood as implying priority for the worst off. For the worst off are those who will face the most serious and immediate harm should they not receive a resource.

Importantly, a needs-based approach to distributive justice exists, at least on some accounts, as an alternative to a utilitarian framework for allocation and not as a mere variant of a utilitarian ethic.²¹ Some theorists may be tempted to adopt a utilitarian interpretation that defines need in terms of a person’s capacity to benefit from a resource. This would, however,

¹⁸ Eric Gustavsson, Niklas Juth. “Principles of need and the aggregation thesis”. *Health Care Analysis* 27;2 (2019): 77-92; 77-78.

¹⁹ *Ibid.*, 91.

²⁰ Harry Frankfurt. “Necessity and desire”. *Philosophy and Phenomenological Research* 45;1 (1984): 1-13; David Wiggins. “Claims of need”. In *Needs, Values, Truth: Essays in the Philosophy of Value* (3rd ed.). London: Oxford University Press, 2002: 1-58; 14-15.

²¹ Cf. Soren Reader. *Needs and Moral Necessity*. London: Routledge, 2007; Gillian Brock (ed.). *Necessary Goods: Our Responsibilities to Meet Others’ Needs*. New York: Rowman & Littlefield Publishers, 1998.

be contrary to the *raison d'être* of need as a distributive principle. A principle of need exists, among other things, as a check on utilitarian logic in the distribution of society's resources. The concept of distribution on the basis of need mandates that we focus on helping those persons in need *rather than* seeking to maximise the utility obtained from our resources.²² Thus, Anders Herlitz and David Horan write that "need satisfaction can be seen as an independent objective [to] other objectives such as health maximisation".²³ We should not, then, apply utilitarian criteria to choices between persons who fall below a threshold of basic need. This would go against the fundamental ethical orientation of a framework of need, at least insofar as the framework has been styled as an alternative to utilitarian approaches to distributive justice.²⁴ We should instead give priority to the claims of persons who are worst off.

Indeed, it would seem that a criterion of need would be redundant unless it is interpreted as focusing on the worst off. If we understood need in terms of capacity to benefit, the criterion would collapse into a utilitarian criterion for rationing. It would cease to perform any distinctive function in ethical deliberation about resource allocation. If we interpret it in terms of priority for the worst off, however, it functions as an independent distributive principle.

An interlocutor might argue that a rejection of utilitarianism does not necessarily entail an interpretation of need in terms of the severity of illness or injury. We might, for example, adopt a strict egalitarian approach to meeting people's health needs instead. Provided people fall below a threshold of serious illness or injury, it could be argued that they have needs of equal

²² Cf. David Baybrooke. *Meeting Needs*. Princeton: Princeton University Press, 2014: Ch.5.

²³ Anders Herlitz, David Horan. "Measuring needs for priority setting in healthcare planning and policy". *Social Science & Medicine* 157 (2016): 96-102; 97. See also Anders Helitz. "Microlevel prioritizations and incommensurability". *Cambridge Quarterly of Healthcare Ethics* 27 (2018): 75-86.

²⁴ Gustavsson and Juth 2019, 91.

seriousness and deserve equal priority.²⁵ They are all very ill, and respect for persons requires that we respond to the claims of need that each individual makes on our resources. As noted earlier, Harris argues that persons in need of treatment should be given equal priority provided that they have at least some capacity to benefit.²⁶

Taking claims seriously, nevertheless, does not require that we treat each claim as being the same. Rather, it means assessing each claim on its merits. If we do this, we are naturally led to a notion of priority, rather than equality, when evaluating people's claims. As Thomas Nagel notes, "the claims on our impartial concern of an individual who is badly-off present themselves as having some priority over the claims of each individual who is better off: as being ahead in the queue, so to speak".²⁷ By attending to the perspective of each person within a domain of distribution, and attempting to make a further judgement about inevitable conflicts between these perspectives, we are led to the conclusion that claims of those who are badly-off take priority over others. Part of what it means to take people's claims seriously – and to *not* adopt a utilitarian approach to resource allocation – is that we give due priority to those who are faring worst.

2. Determining who is most in need²⁸

Let us presume, therefore, that a principle of need requires of us that we allocate resources to those persons who are *worst off*. This presents a challenge, for it is not immediately

²⁵ Cf. Duff Waring. *Medical Benefit and the Human Lottery: An Egalitarian Approach to Patient Selection*. Dordrecht: Springer, 2004.

²⁶ *Ibid.*

²⁷ Thomas Nagel. *Equality and Partiality*. New York: Oxford University Press, 1991: 69; see also Thomas Nagel. "The justification for equality". *Critica* 10;28 (1978): 3-31.

²⁸ This section will focus primarily on need for treatment, rather than need for prophylaxis. Many of the claims made, nevertheless, also apply to the allocation of prophylaxis.

apparent how we should go about identifying the worst off.²⁹ We need to provide some clarity on how we should understand the concept of health shortfall (i.e., the severity of a person's illness or injury) and urgency (i.e., the immediacy of one's need for treatment). It would seem that the worst off will be persons who are a) sickest, and b) in most urgent need of treatment.³⁰ But we also need to consider what capacity a patient has to benefit from treatment. While we have rejected a crude utilitarian approach to healthcare rationing, it would still seem reasonable to suggest that we should not allocate lifesaving resources to patients who have no capacity to benefit from it. In fact, a patient who will not benefit from a treatment has no meaningful *need* for that treatment.³¹ We must, therefore, provide some account of the role that capacity to benefit should play in determining who receives a resource. In what follows I will provide an overview of the concepts of health shortfall, urgency and capacity to benefit. I will discuss what role these criteria should play in determining which claimant is prioritised.

2.1: Health shortfall

The idea of health shortfall refers to both the current illness or injury that a patient is experiencing as well as the future illness or injury that a patient will experience should they not receive access to treatment. Sickness is not just about current symptoms being experienced by a person, but also the deterioration of health that a person will experience in

²⁹ Cf. Dan W. Brock. "Priority to the worse off in health care resource prioritization". In Rosamond Rhodes, Margaret Battin, and Anita Silvers (eds.). *Medicine and Social Justice: Essays on the Distribution of Health Care*. New York: Oxford University Press, 2012: 155-163; 156.

³⁰ I am deliberately focusing on determining who is worst off at present. Some theorists argue that we should consider the whole lives of agents when determining who is worst off. In chapter five, however, I will present some reasons against adopting a lifetime view in our distributive decisions. For an interesting discussion of these different perspectives, see Anders Herlitz. "Health, priority to the worst off, and time". *Medicine, Health Care and Philosophy* 21;4 (2018): 517-527.

³¹ Hasman, Hope and Osterdal 2006, 150.

the future unless they are treated.³² As Herlitz puts it, “health shortfalls...have different temporal locations and different temporal extensions”.³³ Similarly, Nord writes that severity of illness includes “current impairments and symptoms and expected future loss of quality of life and/or length of life due to the illness”.³⁴ Importantly, an intervention that a patient receives now can impact upon their health years and even decades into the future (consider, for example, the long term effects of giving an artificial pacemaker to a patient with heart problems). When allocating resources, then, we should not just consider the immediate impacts that treatments will have but also their long term impacts on a person’s health.

In the case of preventative interventions, health shortfall should be understood as referring to morbidity or mortality that a patient will experience should they *not* receive prophylaxis. Prophylaxis by its very nature is focused on the future health of persons, and, specifically, the prevention of diseases that may affect an individual or group in the future. We should, therefore, understand prophylaxis (for example, vaccination) in terms of the future health shortfall of patients rather than in terms of current health shortfall.

The idea of health shortfall can also be understood in either a *disease specific* sense or in a *holistic* sense.³⁵ A *disease specific* conception of health shortfall pertains to particular conditions and the impact that they have on the bodily functions. Health shortfall with regard to lung cancer, for example, is relative to bodily functions impaired by this form of cancer (for example, respiratory function). A *holistic* conception of health shortfall, in contrast, pertains to

³² Erik Nord. “Priority to the worse off”. In *Inequalities in Health: Concepts, Measures, and Ethics*. London: Oxford University Press, 2013: 66-73.

³³ Anders Herlitz. “Indeterminacy and the principle of need”. *Theoretical Medicine and Bioethics* 38;1 (2017): 1-14; 7.

³⁴ Nord 2013, 67.

³⁵ Cf. Erik Gustavsson. “Patients with multiple health needs for healthcare and priority to the worst off”. *Bioethics* 33;2 (2019): 261-266.

a person's overall bodily and psychological functioning. A person's health shortfall, on this view, would be confined to the bodily functions affected by particular conditions, but would range over all the bodily and psychological functions that we take to be constitutive of human health.

Context is important when determining whether we should focus on disease specific health shortfall or holistic health shortfall. One must reflect in particular situations on what is the "morally relevant sense of being worst off".³⁶ Plausibly, one should consider the overall health wellbeing of persons in scenarios such as the allocation of vaccines in a pandemic. In an influenza pandemic, comorbidities play a significant role in determining who is most vulnerable to contracting an illness should they not receive prophylaxis.³⁷ It stands to reason that one should consider comorbidities when determining which candidates for vaccination are *worst off*. In other contexts, however, it is appropriate to focus on a patient's primary illness when we are deciding which patients should receive lifesaving treatment. One example would be decisions involving the allocation of scarce vital organs for transplantation. In this case, a patient's primary illness – such as heart disease or Chronic Obstructive Pulmonary Disorder (COPD) – would be one of the main considerations (if not *the* main consideration) in determining whether or not they receive a transplant.

2.2: Urgency

It is also appropriate to consider urgency when evaluating people's claims on scarce healthcare resources. Urgency refers to the rapidity with which a patient must receive access to treatment if they are to avoid serious health-related harm. Patients with aggressive illnesses

³⁶ Barra *et al* 2019, 9.

³⁷ Dominik Mertz *et al*. "Populations at risk for severe or complicated influenza illness: systematic review and meta-analysis". *British Medical Journal* 347 (2013): 347.

often require immediate treatment if they are to avoid a further deterioration in health. Similarly, persons who face a more immediate risk of contracting a virus in a pandemic scenario have a more *urgent need* of receiving prophylaxis than persons who are not at immediate risk from the virus.

Some theorists argue that urgency also relates to a patient's health shortfall, for to some extent the urgency with which a patient needs treatment is a function of the seriousness of their illness. Frances Kamm, when discussing organ allocation, defines urgency both in terms of "how soon someone will die without a transplant" and "how badly-off someone will be without a transplant *soon*".³⁸ Urgency, on this view, is partly a function of a person's ongoing poor state of health. It not only matters whether a person will die or experience a deterioration in health, but also whether they will continue to experience debilitating symptoms should they not receive an intervention.

I would argue, however, that it is important not to conflate health shortfall and urgency, as the two concepts are not coextensive. Someone can be seriously ill, for example, while not facing any immediate risk of deterioration in their health. For example, a patient who sustained serious injuries in a car accident could be in a stable condition in ICU, supported by a mechanical ventilator, intravenous blood transfusions, and a PEG tube. In this sense, they are experiencing a serious health shortfall, while not requiring urgent treatment. We have reason, then, to separate the concepts of health shortfall and urgency. Granted, the fact that someone is seriously ill may indicate ongoing pain, suffering and debility, even though their condition will not strictly speaking *decline*. For the sake of clarity, however, I will not conflate urgency and health shortfall. Keeping the concepts of health shortfall and urgency separate will allow

³⁸ Cf. Kamm 1998, 234. See also Dan Brock 2012, 161.

us to make more fine-grained distinctions between patients. It should suffice to include a patient's symptoms in the category of health shortfall, and prioritise the patient on this basis.

Some critics are reluctant to adopt a criterion of urgency when determining which patient should receive access to lifesaving treatment, as patients who are not in urgent need of treatment now may have urgent need of treatment in the future.³⁹ Yet we cannot always guarantee that we will have the same resources available in the future as we have available now. In light of this, critics argue that we should not consider the urgency with which a patient needs treatment when determining who we should allocate resources to.

As a further gloss on this objection, it is instructive to consider Kamm's account of the three kinds of healthcare scarcity. The three types of scarcity that Kamm identifies are *true scarcity*, *temporary scarcity*, and *a condition of uncertainty*. True or absolute scarcity refers to a situation where we know that the persons who miss out on a resource now will not receive an appropriate resource in the future. In the case of organ transplantation, for example, we may know that "if we give an organ to one person rather than another, the person who does not get it will never get another of the same type".⁴⁰ True scarcity can be contrasted with temporary scarcity. In temporary scarcity, we know that someone who does not receive an intervention now will get another chance to receive the intervention in the future. And so, a patient in need of a kidney transplant who does not receive one now will get the chance to receive a transplant in the future. Finally, a condition of uncertainty refers to situations where we do not know if a person will face either true or temporary scarcity. It may, for example, be unclear what kinds

³⁹ Persad, Wertheimer, Emanuel 2009, 423-431; 425; Dan Brock. "Health care resource prioritization and rationing: why is it so difficult?". *Social Research* 74;1 (2007): 125-148; 138-139; Leonard Fleck. "Health care rationing, terminal illness, and the medically least well off". *The Journal of Law, Medicine and Ethics* 39;2 (2011): 156-171.

⁴⁰ Kamm 1998, 233.

of organs will be available in the future. In such a situation, we are uncertain about whether someone who misses out an organ now will receive one in the future.

In response, urgency is a criterion that should be given moral weight in situations of temporary scarcity and in conditions of uncertainty. If we do not give treatment immediately to a person with less urgent needs, there is at least some chance – in situations of temporary scarcity and in conditions of uncertainty – that we will be able to supply them with appropriate treatment in the future. In a situation of true or absolute scarcity, however, we should think carefully about whether it is appropriate to apply an urgency criterion.⁴¹ If we have only one lifesaving resource to go between multiple candidates, and we know that no further resources will become available, it could be argued that all candidates have an equal level of need relative to this sole precious resource. All of the candidates face death should they not receive the resource, even if death will come sooner to some than others.

It may be morally relevant that, in the case of transplantation, one patient has five years to live before they need a transplant while another patient will die within months if they do not receive a graft. The patient facing imminent death stands to lose more years of life, *ceteris paribus*, should they not receive the resource. In extreme circumstances, then, we may choose to prioritise the patient facing imminent death even despite the fact that other patients will themselves eventually die if they do not receive the scarce resource. Where patients have needs that are quite similar, however, we have less reason to employ an urgency criterion (presuming we are operating under conditions of absolute scarcity). Urgency is a criterion that is more relevant to situations where we are dealing with temporary scarcity or conditions of uncertainty.

⁴¹ Kamm 1998, 223.

2.3: Capacity to benefit

The criteria of health shortfall and urgency both pertain to how badly-off a patient is. The criteria of capacity to benefit, in contrast, pertains to a patient's capacity to obtain health-related gains from treatment. This criterion concerns how much utility a treatment will have for a patient – both now and in the future.⁴² Some theorists argue that a person's need for treatment is proportionate to their capacity to benefit from treatment.⁴³ I will argue, however, that capacity to benefit should be understood as a minimum threshold that patients must meet if they are to be considered in need of (and eligible for) treatment. Beyond this, it is irrelevant to determining a patient's level of need.

There is an uncontroversial sense in which capacity to benefit is relevant to the concept of health need. This is, namely, that patients must have *some* capacity to benefit from treatment if they are to be said to be in need of treatment.⁴⁴ Without even the slightest capacity to benefit from a treatment, there is no meaningful sense in which a patient can be said to *need* that treatment. To administer the treatment in these cases would be medically futile. By medical futility, I have in mind interventions that would yield negligible health benefits or no benefits at all for a patient. In these situations, the patient does not actually have a *need* for the treatment in any meaningful sense of the word. As such, they should not be considered eligible for receiving a scarce resource.

⁴² Herlitz 2018, 4.

⁴³ See, for example, Jeremiah Hurley *et al.* "Medical necessity, benefit, and resource allocation in health care". *Journal of Health Services Research & Policy* 2;4 (1997): 223-230; Alan Williams. "Ethics and efficiency in the provision of healthcare". *Royal Institute of Philosophy Supplements* 23 (1988): 111-126. For a nuanced discussion of the idea of health benefit, see Greg Bognar, Iwao Hirose. *The Ethics of Health Care Rationing: An Introduction*. London: Routledge, 2014.

⁴⁴ Jon Elster. "The idea of equality revisited". In J.E.J. Altham, Ross Harrison (eds.). *World, Mind, and Ethics: Essays on the Ethical Philosophy of Bernard Williams*. Cambridge: Cambridge University Press, 1995: 4-18; 7-8.

Even still, futility is a very low threshold for establishing a *need* for treatment. The mere fact that a treatment will not be manifestly harmful to a patient, or may have some small benefit for that patient, is not necessarily sufficient for determining that a patient has a *need* for treatment (i.e., that treatment is clinically indicated). A patient on the verge of death may, for example, be expected to gain one month of extra life if they receive an organ transplant, but it is unclear that this increase in life expectancy is sufficient for the patient to be considered to have a *need* for an organ transplant. As Jos Welie and Henk Ten Have observe:

“when health can no longer be achieved, when life’s end is nearing, when suffering is severe and the means to relieve it have themselves nasty side-effects, it is suddenly no longer self-evident what is in the patient’s best interests, neither to the health care professionals, nor to the patients’ family members or even the patients”.⁴⁵

It is, therefore, misguided to argue that *any* capacity to benefit, no matter how minimal, means that treatment is advisable. James Kahan *et al* make a similar observation when they write:

“a procedure is necessary [if] the benefit to the patient is not small. Procedures that provide only minor benefits are not necessary”.⁴⁶

A patient would not be considered *in need* of a scarce intervention, on this view, if they only stood to obtain minor benefits from it.

Rather, it is widely held that a patient should be capable of obtaining a *significant and meaningful benefit* from treatment.⁴⁷ The thought is that a patient must be capable of benefiting enough from treatment such that a treatment could be labelled *clinically appropriate* or

⁴⁵ Jos Welie, Henk Ten Have. “The ethics of forgoing life-sustaining treatment: theoretical considerations and clinical decision making”. *Multidisciplinary Respiratory Medicine* 9 (2014): 14; 6.

⁴⁶ James Kahan *et al*. “Measuring the necessity of medical procedures”. *Medical Care* 32;4 (1994): 357-365; 359.

⁴⁷ See, for example, Colleen Gallagher, Ryan Holmes. “Handling cases of medical futility”. *HEC Forum* 24;2 (2012): 91-98; Lawrence Schneiderman. “Defining medical futility and improving medical care”. *Journal of Bioethical Inquiry* 8 (2011): 123-131; 129; Waring 2004, 141-147.

medically indicated for that patient.⁴⁸ The idea of a significant and meaningful benefit is, admittedly, difficult to define, as the meaning of this term will differ depending on the clinical situation one is dealing with. A trivial benefit would not meet this threshold, however, as the standard is to some extent defined in contrast to the idea of trivial benefits. Rather, a patient must benefit in a manner that outweighs countervailing considerations such as the burdens of treatment.

There are a number of considerations that should plausibly form part of our conception of *significant and meaningful benefit*. One must, for example, be “very carefully assess the specific goals of continued treatment” for a patient.⁴⁹ The meaningfulness of benefits will be determined by a range of clinical considerations – including judgements about the increase in life expectancy and quality of life that is anticipated from treatment – as well as moral considerations. Judgements must be made about *the patient’s good* and *the patient’s best interests*.⁵⁰ These are value laden concepts, and for this reason, it is imperative to consider both a patient’s subjective perception of benefits as well as objective facts about expected treatment outcomes.⁵¹

The further we move away from a conception of futility, however, the more contentious our judgements about benefit become. As Waring observes, “moving away from physiological futility can involve contentious value differences about whether responses to treatment that some might consider worth having amount to benefits worth providing”.⁵² It would seem that

⁴⁸ Philip Rosoff. *Drawing the Line: Healthcare Rationing and the Cutoff Problem*. London: Oxford University Press, 2018: 82-87.

⁴⁹ Welie and Have 2014, 6.

⁵⁰ Cf. Dominic Wilkinson. “A life worth giving? The threshold for permissible withdrawal of life support from disabled newborn infants”. *American Journal of Bioethics* 11;2 (2011): 20-32.

⁵¹ *Ibid.*, 7.

⁵² Waring 2004, 141.

there is a spectrum of reasonable views on what counts as a significant and meaningful benefit from lifesaving healthcare resources. Indeed, Herlitz goes as far as to argue that the idea of health need is a “partially indeterminate” concept, such that we may not be able to say for sure what the threshold of benefit should be for someone to count as having a need for treatment.⁵³

In light of this, several theorists have argued that both clinicians and the community should be included in the decision-making about the eligibility criteria for scarce healthcare resource allocation.⁵⁴ A process of stakeholder consultation can assist in ensuring that judgements about the good of the patient retain some degree of objectivity and consistency. In consulting relevant stakeholders, we can move towards a position intersubjective agreement on what constitutes a significant and meaningful benefit from treatment.⁵⁵ Indeed, in the latter chapters of this thesis I will argue that – when it comes to determining which patients are eligible for interventions such as an organ transplantation – a threshold of capacity to benefit should be determined by healthcare professionals in consultation with patients and the public.

It could be argued that the inclusion of the notion of *significant and meaningful benefit* in our conception of need undermines the *raison d’être* of a criterion of need. It may seem that we are making allocation on the basis of need conditional on a person’s capacity to benefit. I argued earlier, however, that need should be defined in terms of how badly-off a person is *rather than* their capacity to benefit. We should not, then, be imposing arbitrary capacity to benefit thresholds on patients in need of lifesaving care. As Persad *et al* note, it would be

⁵³ Anders Herlitz. “Indeterminacy and the principle of need”. *Theoretical Medicine and Bioethics* 38 (2017): 1–14. See also Anders Herlitz. “The limited impact of indeterminacy for healthcare rationing”. *Journal of Medical Ethics* 42 (2016): 22-25.

⁵⁴ See, for example, Rosoff 2016, 82-86; Waring 2004, 143-146; Cheryl Misak *et al*. “Medically inappropriate or futile treatment: deliberation and justification”. *Journal of Medicine and Philosophy* 41;1 (2016): 90-114.

⁵⁵ Cf. Norman Daniels. *Just Health: Meeting Health Needs Fairly* (London: Cambridge University Press, 2008): 117-139.

misleading to say that “sick people with a small but clear chance of benefit” do not have a *need* of treatment.⁵⁶

A threshold of capacity to benefit, however, should not be seen as conflicting with the *raison d’être* of a criterion of need. Rather, it accommodates for what is considered a medically appropriate or clinically indicated treatment for a patient. There are some treatments that, while not being strictly speaking futile, will nevertheless have a negative impact on the quality of life of a patient, and may not significantly increase their life expectancy. As such, it may not be appropriate to provide treatment to patients in this situation. The idea of *significant and meaningful benefit* should be based on what clinicians, patients and the public believe is an appropriate benefit threshold for the cohort of persons in need of a lifesaving healthcare resource. It should mark off the group of patients who stand to gain enough from treatment such that our allocation of resources to them would be genuinely beneficial.⁵⁷

It is apposite here to discuss the role that probability plays in determining a person’s need for treatment. Very few medical interventions are certain of being effective. Rather, most interventions are effective in only a proportion of patients with a relevant condition. Furthermore, a patient’s prognosis without an intervention is sometimes unclear. These two variables, then, must be accounted for in any plausible theory of the normativity of health needs.⁵⁸

For the sake of argument, let’s presume we are dealing with an intervention that is life-prolonging (i.e., an intervention that is intended to bring about an increase in the life

⁵⁶ Persad, Wertheimer and Emanuel 2008, 425.

⁵⁷ Waring 2004, 139-143.

⁵⁸ Federico Nicoli *et al.* “If an acute event occurs, what should we do?’ Diverse ethical approaches to decision-making in the ICU”. *Medicine, Health Care and Philosophy* (2019): 1-12.

expectancy of a patient who is facing imminent death). In this case, Hope *et al* suggest that we should have a calculation that takes into account the probability (x) that the patient will live with no intervention; and the probability (y) that the patient will live with the (relevant) intervention.⁵⁹ But it is not immediately apparent how these variables should inform our understanding of the concept of need. It is unclear when the probability of success of an intervention becomes so negligible that the intervention ceases to be needed in any meaningful sense of the word. It is also unclear what probability of living without an intervention a patient must have if they are to fall within the range of *need*. Someone who has an infinitesimally small chance of losing their life as a result of a sudden heart attack does not necessarily *need* special interventions to prevent a heart attack from happening. Rather, it is only when the threat of loss of life as a result of a particular condition becomes significant that we start to talk of that person as needing prophylactic interventions. Still, it is unclear when a health risk becomes *significant*.

Probability (y) is largely irrelevant to medical need provided that a treatment has a non-negligible chance of success. Medical need is primarily dependent on the notion of health shortfall, and provided that a person has a small but non-negligible chance of benefiting from a treatment, they plausibly can be said to have a *need* for that treatment. Granted, there may be other factors that ultimately militate against providing the treatment to that individual. There may be some other individual who is more in need of the treatment, for example. Yet this does not negate the fact that treatment has a non-negligible chance of ameliorating the symptoms of the patient in question.

An interlocutor might argue that treatments are needed to the extent that they are likely to succeed. In this sense, treatments with a greater probability of success are more needed by

⁵⁹ Hope, Osterdal, Hasman 2010, 475.

patients than treatments with a lesser probability of success. Yet this would really be a question about the utility of treatments rather than a question of the level of need of patients. The level of need of patients is largely independent of the probability of success of an intervention. The role that probability of success plays in determining need should be limited to a minimum threshold of capacity to benefit. What we are dealing with, in this case, is just another dimension of the concept of medical futility, namely, the futility of administering a treatment that has a negligible probability of success.⁶⁰

We should not, then, pursue treatments with little chance of success. As Schneiderman observes, the pursuit of burdensome treatments with a low probability of success may actually violate the bioethical principle of non-maleficence. He writes:

“If you truly want to make a case for attempting aggressive, life-sustaining, rib-cracking CPR on a patient who has a “one in a hundred chance” of working, you are claiming that it is appropriate to subject ninety-nine patients to an intervention that is painful, burdensome, and almost certainly useless in pursuit of one possible rare success”.⁶¹

Clearly, such a treatment would violate medicine’s duty to avoid unnecessary harm. And so we should not pursue treatments with an extremely low probability of success.

Patients *should*, nevertheless, be considered eligible for treatment provided they have a non-negligible probably of benefitting from treatment. This position is compatible with Schniederermann’s observation that treatments with a low probability of success should not be pursued. Plausibly, a patient with a very low probability of benefitting from treatment does not have a clinical need for treatment.⁶² A patient who has a non-negligible chance of experiencing

⁶⁰ Schneiderman 2011, 124-125.

⁶¹ *Ibid.*, 125.

⁶² *Ibid.*; Rosoff 2018, 107-112.

significant benefits, in contrast, should be afforded access treatment, provided that the likely benefits of treatment outweigh any countervailing burdens resulting from an intervention. A patient with glioblastoma, for example, may have a 20% (one in five) chance of benefitting from an experimental, lifesaving treatment that has few side-effects. A one in five chance is small but non-negligible. The patient has at least a *prima facie* claim on the experimental treatment, even if their claim is ultimately outweighed by the strength of the claims of other patients.

In chapter seven, we will explore another dimension of probability that is relevant to need. This is, namely, the probability that a person will fall ill and experience death without a prophylactic intervention. Someone can be said to be more in need of vaccination insofar as they have a greater probability of contracting an illness and also a greater likelihood of dying should they be infected by the illness. Probability in this sense is very relevant to a criterion of need.

2.4: Summary

In this section, I have discussed three constituent features of health need: health shortfall, urgency, and capacity to benefit. According to the framework presented, the patients who are *worst off* are those who a) are experiencing the greatest health shortfall, and b) are in most urgent need of treatment. I defined the concept of health shortfall as the overall shortfall in health that a patient experiences (and will experience) with respect to biological and psychological indices of human health. I defined the concept of urgency as the immediacy with which a patient needs treatment if they are to avoid some serious health-related harm. I argued that urgency is particularly relevant when we are dealing with temporary scarcity or conditions of uncertainty. It is less relevant where we are dealing with absolute scarcity. I also alluded to the need for patients to meet a minimum threshold of capacity to benefit from treatment.

3. Applying a criterion of need to the allocation of lifesaving healthcare interventions

We can now consider how a criterion of need provides concrete guidance for the allocation of lifesaving treatments under conditions of scarcity. A framework of respect for persons, as outlined in the previous chapter, leads us to prioritise the person or persons with the strongest claim on resources. In this chapter, I have outlined a conception of need with which we can assess the strength of the claims that persons make on scarce lifesaving healthcare interventions.

According to this account of health needs, we should prioritise the person or persons who – of those individuals who meet a threshold of capacity to benefit – is the sickest and most urgently in need of treatment. From a purely clinical point of view, a treatment may be said to be needed to the extent that a patient stands to benefit from that treatment. But as Horne observes, this “does not tell us how urgent or important it is, morally speaking, to treat a particular condition”.⁶³ I have argued that we should keep separate the concepts of need and capacity to benefit, provided a patient meets a minimum benefit threshold.⁶⁴ Rather, our conception of need should track how badly-off a patient is relative to the physiological and psychological indices of health.

Importantly, concepts such as health shortfall are context sensitive, and our account of *the worst off* will differ based on the intervention that we are allocating.⁶⁵ For cancer interventions, for example, the worst off patients will be those who have end stage cancer and will die soon if no treatment is administered. For a mechanical ventilator, the worst off patients will be those

⁶³ L. Chad Horne. “Medical need, equality, and uncertainty”. *Bioethics* 30;8 (2016): 588-596; 589. See also Donna Dickenson. “Can medical criteria settle the need priority setting debates? The need for ethical analysis”. *Health Care Analysis* 7;2 (1999): 131-137.

⁶⁴ Cf. Herlitz and Horan 2016, 97.

⁶⁵ Gustavsson 2019, 4-5.

who are most seriously ill and most at risk of death without ventilation. In the later chapters of this thesis, I will provide a detailed account of how this applies to two other concrete resource allocation scenarios – the allocation of vital organs and the allocation of vaccines and treatment in a pandemic scenario.

I am, however, assuming that we are dealing with a situation of temporary scarcity or a situation of uncertainty. It is only under these circumstances that claimants with the most serious health needs should be prioritised. In situations of true or absolute scarcity, we may have reason to treat all claimants equally, insofar as they will not get another chance at accessing treatment. This is not a trivial point, as a large part of what has driven revisionary scholarship on the allocation of lifesaving interventions has been the fact that we cannot be sure that if we meet the needs of those who are worst off now we will be able to meet others' needs in the future.⁶⁶ The final section of this chapter will deal specifically with scenarios where we must allocate treatment between patients with equally strong claims of need.

In the following section, however, I will consider some of the challenges encountered when applying a framework of need to the allocation of lifesaving healthcare interventions. I will address two objections to the application of a principle of need. The first pertains to the supposed inefficiency resulting from a framework focused on health needs. The second objection relates to the fact that all persons vying for a lifesaving resource are already very ill. As such, it might be argued that they all have a roughly equal need of treatment. I will also consider how we should allocate treatment when we are dealing with patients with equivalent needs.

⁶⁶ Persad, Wertheimer and Emanuel 2008, 424.

4. Common objections to the application of a needs-based framework to the allocation of lifesaving healthcare interventions

It should be noted that the frameworks to be explored in later chapters of this thesis constitute objections to the use of a criterion of need in healthcare rationing. The objections discussed in this section should not be taken to exhaust the criticisms that can be made of a needs-based framework for assessing health-related claims.

One common objection is that a criterion of need is inefficient.⁶⁷ We do not get the most out of our healthcare resources when we allocate them to patients who are worst off. Those who are worst off may not have the greatest capacity to benefit out of all candidates vying for the resource; in fact, need is often negatively correlated with capacity to benefit. And so we will not obtain the full utility to be had from the scarce resources being allocated. There is also a related concern about priority for the worst off functioning as a *bottomless pit* of healthcare resource consumption, where people who are very ill consume large amounts of healthcare resources with only limited benefits.⁶⁸ It could be argued that we should instead allow a utilitarian principle to direct allocation when we are dealing with lifesaving healthcare interventions, as this would ensure that we obtain maximal utility from these resources. And where people's lives are at stake, we should be adopting an approach that maximises utility. This, rather than a needs-based approach, is what it means to show concern for human life, or so it might be argued.⁶⁹

⁶⁷ See, for example, Daniel Strech, Marion Danis. "How can bedside rationing be justified despite coexisting inefficiency? The need for 'benchmarks of efficiency'". *Journal of Medical Ethics* 40 (2014): 89-93.

⁶⁸ Juth 2015, 78-79.

⁶⁹ Mark S. Stein. "A utilitarian approach to justice in health care". In Rosamond Rhodes, Margaret Battin, and Anita Silvers (eds.). *Medicine and Social Justice: Essays on the Distribution of Health Care*. New York: Oxford University Press, 2012: 47-56.

The next chapter will discuss utilitarian approaches to rationing in detail. Suffice to say here that a utilitarian framework fails to recognise the moral authority that people have to make claims on our assistance. Rather, it distributes healthcare resources based on health-related outcomes such as quality of life, life extension, or number of lives saved. In doing this, the maximisation of utility is given precedence over an engagement with individual claims. I have argued, however, that we should consider how each individual claim compares to every other individual claim.⁷⁰ Those with the strongest claim on resources are those who have the most serious and urgent needs. It is these individuals, not people with the greatest capacity to benefit, who we should be prioritising. I am, however, willing to concede that recipients of scarce lifesaving resources should be expected to meet a minimum threshold of capacity to benefit. And so, while I do not think we should focus on the maximisation of utility alone, I am not advocating a wasteful use of resources. I believe that capacity to benefit should function as an initial threshold of eligibility for access to lifesaving medical care.⁷¹

Second, it might be argued that need is a bad principle for situations involving lifesaving resources, for everyone who needs a lifesaving resource is very ill already. Indeed, when we are allocating lifesaving healthcare interventions there will be many situations where we are dealing with multiple people who will die if they do not receive access to the resource being allocated. In these situations, it would be foolish to attempt to distinguish candidates on the basis of need. For the candidates have equal levels of need – they will die if they do not receive the resources. As such, it seems we should adopt egalitarian criteria for allocation. It might be

⁷⁰ Cf. John Taurek. "Should the numbers count?". *Philosophy & Public Affairs* 6;4 (1977): 293-316.

⁷¹ Cf. Waring 2004, ch.9.

suggested, for example, that we should adopt a random allocation mechanism, or a first come, first served policy.⁷²

We should treat people equally where they face an equally serious threat to their lives. In the next section of this chapter, I will argue in favour of a random allocation mechanism in these scenarios. Real-life health care scenarios, however, rarely involve a *tie* between patients. Rather, meaningful distinctions can be drawn between patients based on the severity of their illness and the immediacy with which they need treatment or prophylaxis.⁷³ People will have a greater or lesser risk of morbidity or mortality depending on a range of factors. The criteria of health shortfall and urgency are intended to allow us to identify these differences. Often it will be the case that one patient will have a much greater likelihood of imminent death should they not receive treatment or prophylaxis, and in these situations it seems fair to say that we should prioritise the patient who faces the greatest risk of death.

Policies must, nevertheless, balance a concern for the worst off with the expected likelihood that treatment or prophylaxis will be provided to other members of the population. In conditions of uncertainty, there will always be a risk that prioritising the worst off *now* may result in us not having sufficient resources to provide treatment or prophylaxis to those who are worst off in the *future*. Ironically, the worst off may receive several years of additional life through treatment or be protected through prophylaxis from a deadly virus, yet those who are in only a marginally better state of health will completely miss out on treatment or prophylaxis. A criterion of need, then, runs the risk of replacing one health inequality with another. It can be

⁷² Hugh McLachlan. "A proposed non-consequentialist policy for the ethical distribution of scarce vaccination in the face of an influenza pandemic". *Journal of Medical Ethics* 38;5 (2012): 317-318.

⁷³ Alistair Wardrope. "Scarce vaccine supplies in an influenza pandemic should not be distributed randomly: a reply to McLachlan". *Journal of Medical Ethics* 38 (2012): 765-767.

unfairly partial to those who face an immediate threat to their life. Policy makers should take into account just how great this risk is when developing protocols for allocation.

There are some theorists who suggest that we should always be prepared to give preferential treatment or prophylaxis to those who are facing an immediate threat of death.⁷⁴ Indeed, several scholars have defended the so-called *rule of rescue*, or the idea that there is a moral imperative to help those who are at immediate risk of mortal peril.⁷⁵ It could be argued that the rule of rescue provides justification for an unequivocal endorsement of priority for the worst off. Yet I would argue that we should be cautious about always following rule of rescue. The rule of rescue provides useful guidance for everyday emergency situations. Yet its value is less clear in situations of scarcity, where we are dealing with many people who are facing death if they do not receive treatment or prophylaxis.⁷⁶ In these situations, we arguably must be more judicious in deciding who we should help. A refined understanding of the concept of need can assist us in making prudent choices in situations of uncertainty.

5. Resource allocation among persons with claims of equal strength

In the remainder of the chapter, I will consider how we should proceed when we are dealing with multiple persons with equally strong claims on lifesaving treatment. In some situations, it may be the case that we are unable to distinguish between the severity and urgency of the health needs of different persons. In such situations, we need alternative criteria that, while

⁷⁴ Cf. Richard Cookson, Paul Dolan. "Principles of justice in healthcare rationing". *Journal of Medical Ethics* 26 (2000): 323-329; 324.

⁷⁵ See, for example, John McKie, Jeff Richardson. "The rule of rescue". *Social Science and Medicine* 56;12 (2000): 2407-2419; Mark Sheehan. "Resources and the rule of rescue". *Journal of Applied Philosophy* 24;4 (2007): 352-366;

⁷⁶ Tony Hope. "Rationing and life-saving treatments: should identifiable patients have higher priority?". *Journal of Medical Ethics* 27 (2001): 179-185. See also Richard Cookson *et al.* "Public healthcare resource allocation and the rule of rescue". *Journal of Medical Ethics* 34 (2008): 540-544.

not discriminating between patients on the basis of arbitrary criteria, nevertheless allow us to determine which claimant we should prioritise.

Few would argue that we should not give the resource to anyone in situations where several patients have an equally strong claim on it. As Bognar and Kerstein have observed, “saving no one is surely incompatible with respect for persons”.⁷⁷ Yet many theorists have suggested that we should take into account age, utility, or desert when attempting to distinguish between candidates in these situations. These criteria, it is claimed, are appropriate as a “counsel of despair” when we are required to make difficult decisions about who receives access to treatment.⁷⁸

Yet these approaches conflict with a distributive framework based on respect for persons. They ration care based on factors that are irrelevant to the claim that persons make on lifesaving resources. In this way, they fail to take people’s claims of need seriously. Rather than rationing care on the basis of age, utility or desert, I would argue that we should base our decisions on criteria that do not involve judgement about the value of patients’ lives, or claims about how worthy they are of receiving treatment. We should ration care based on impartial mechanisms that reflect the fact that patients have claims of equal strength.

5.1: A lottery criterion

⁷⁷ Bognar and Kerstein 2010, 6.

⁷⁸ See, for example, John Harris. *The Value of Life: An Introduction to Medical Ethics*. London: Routledge, 1985: 90-94; 94.

One criterion for rationing that has received significant attention in recent years is a lottery principle.⁷⁹ By a lottery principle, theorists are referring to a mechanism that prioritises patients on the basis of a random selection process. A lottery allows for patient selection while respecting the claim that each person has on the resource in question. Indeed, I will argue that it does justice to the fact that candidates have claims of equal strength and are deserving of equal consideration, for it is an impartial means of selecting candidates to receive a resource.

John Broome argues that lotteries provide a *surrogate satisfaction* of the claims that persons have on resources.⁸⁰ Specifically, Broome argues that a lottery satisfies, albeit imperfectly, the claim that a person has on a resource by giving the person a *chance* of receiving the resource. The mere chance of receiving the resource is of value in and of itself, or so Broome argues. He writes:

“...a sort of partial equality in satisfaction can be achieved. Each person can be given a sort of surrogate satisfaction. By holding a lottery, each [claimant] can be given an equal chance of getting the good. This is not a perfect fairness, but it meets the requirement of fairness to some extent”.⁸¹

The thought is that a lottery is a fair procedure even if it does not allow for everyone’s claims to be fully satisfied. What it does allow for, according to Broome, is a *proportionate satisfaction of claims*, as claimants are given a stake in the resource lottery.⁸²

⁷⁹ See, for example, Ben Saunders. “The equality of lotteries”. *Philosophy* 83 (2008): 359-372; Iwao Hirose. “Weighted lotteries in life and death cases”. *Ratio* 20;1 (2007): 45-56; Barbara Goodwin. *Justice By Lottery*. London: Oxford University Press, 1992.

⁸⁰ John Broome. “Fairness”. *Proceedings of the Aristotelian Society* 91 (1990 - 1991): 87- 101.

⁸¹ *Ibid.*, 97-98.

⁸² Broome 1991, 98.

Yet several theorists have objected to this argument. Critics note that the only reason why a stake in a lottery might be valuable is because of the connection it bears to the good that the lottery is allocating.⁸³ Insofar as a lottery participant misses out on that good, their stake in the lottery can be said to have been of no value. When viewed *ex post*, the chance of receiving a resource is valueless insofar as it did not in fact lead to someone receiving the resource. As Tim Henning notes:

“...chances that one has received are not substantive benefits...Their only relevance is as weights in calculating expected value, weights that change to zero or one once the outcome is known”.⁸⁴

A chance of receiving a resource, then, is of no real benefit to a person unless it actually leads to a person receiving that resource. It is misguided to think that lotteries provide even a partial satisfaction of claims.⁸⁵ As Stone states, “one cannot, after all, eat chances”.⁸⁶

Yet this criticism does not mean that lotteries are unjustifiable as a procedure for rationing. While lotteries may not produce an *outcome* in which everyone’s claims are satisfied, they still provide a just *procedure* for determining who, out of those with equivalent claims, should receive a resource. Lotteries are a random allocation mechanism that does not involve one candidate being favoured over another for morally irrelevant reasons. As Stone notes, lotteries embody the procedural norm of equal concern, and ensure that “bad reasons be kept out of the decision”. Lotteries allow for this as “they make decisions on the basis of *no* reasons”.⁸⁷ It

⁸³ Tim Henning. “From choice to chance: saving people, fairness, and lotteries”. *Philosophical Review* 124;2 (2015): 169-206.

⁸⁴ *Ibid.*, 177.

⁸⁵ Daniel Hausman. *Valuing Health: Well-being, Freedom, and Suffering*. London: Oxford University Press, 2015: 206-208.

⁸⁶ Peter Stone. “Why lotteries are just”. *The Journal of Political Philosophy* 15;3 (2007): 276-295; 281.

⁸⁷ Peter Stone. *The Luck of the Draw: The Role of Lotteries in Decision Making*. London: Oxford University Press, 2011: vii.

would be wrong for a human being to prioritise one person over others with equally strong claims based on morally irrelevant factors. A lottery, in contrast, gives persons an equal chance of receiving a resource. As such, it is fully compatible with the view that individuals with equivalent needs have an equal claim on our healthcare resources.

Some theorists object to this conclusion. Shlomi Segall acknowledges that lotteries provide a fair procedure of distribution; yet he argues that this is insufficient to render the outcomes of lotteries fair. Lotteries lead to outcomes in which some people's claims are not satisfied, and this *ipso facto* means that the outcomes are "unjust". Segall writes:

"...while lotteries are (no doubt) the proper way to allocate indivisible goods (such as kidneys), they nevertheless result in unfairness, since the loser in the draw has suffered bad brute luck. And crucially, it is a case of brute (rather than option) luck because it would have been unreasonable to expect the agent (the patient in this case) to refrain from entering the draw. Conducting a lottery is thus justified while nevertheless leading to an injustice. It generates a brute luck disadvantage".⁸⁸

Segall is of the opinion that there is no means of achieving a fair outcome for the allocation of scarce resources like kidneys.

I disagree with the claim that lotteries lead to unfair outcomes. More to the point, I would argue that fairness, in this case, is a function of procedure rather than outcome. That is to say, what we are looking for in tie-breaker situations is a fair procedure rather than an outcome in which everyone's claim is satisfied. It has already been ascertained that we cannot satisfy everyone's claims. In lieu of this, we must look for a procedure that allows us to deal fairly with candidates. A lottery is an impartial procedure that selects a candidate at random. This is enough to meet

⁸⁸ Shlomi Segall. "Peter Stone, The Luck of the Draw: The Role of Lotteries in Decision-Making". *Notre Dame Philosophical Papers* published online 19th December 2011. Available from <http://ndpr.nd.edu/news/27864-the-luck-of-the-draw-the-role-of/>.

the requirements of procedural justice. For what we are looking for is an equitable and impartial way of allocating a resource. And an impartial process like a lottery gives each candidate an equal chance of accessing a resource.

Perhaps Segall might be suggesting that lotteries are an example of what Rawls would call imperfect procedural justice. That is, lotteries are designed to deliver equitable outcomes, yet they inevitably will lead to some people being treated inequitably. An analogy would be a criminal trial. The rules of a criminal trial are designed to ensure that a defendant is declared guilty only when they have committed a crime. Yet, as Rawls observes, "...it seems impossible to design the legal rules so that they always lead to the correct result...even though the law is carefully followed, and the proceedings fairly and properly conducted, it may reach the wrong outcome".⁸⁹ In situations such as a lottery or a criminal trial, in other words, a degree of injustice is to be expected.

But a lottery is not an example of imperfect procedural justice. A lottery is different in morally relevant respects from the shortcomings of criminal justice. Rawls' worry with the criminal justice system is that it will sometimes lead to an innocent person being convicted of a crime (which would be an unjust outcome). Yet it is hard to see what the analogy is with a lottery. A lottery will lead to some persons who have a claim on a resource missing out on accessing that resource. Yet this would not be unjust in the sense of a person being found guilty of a crime they didn't commit. Crucially, candidates do not have a right to have their claims satisfied. They only have a right to have their claims taken seriously, and this means giving each claim due consideration in our procedures for allocation. In the case of a lottery, each claim is taken seriously insofar as the claimant is included in the lottery. A lottery gives each claimant an equal chance of receiving the resource. This is sufficient to fulfil our duties towards

⁸⁹ John Rawls. *A Theory of Justice* (revised ed.). Cambridge, MA: Belknap Press, 1999: 75.

claimants; we do not have a duty to actually supply them with the resource when the resource is scarce and we cannot meet everyone's needs.

5.2: A waiting list

This should suffice for a preliminary discussion of a lottery criterion. Importantly, there are real-world healthcare resource allocation criteria that mirror the impartiality and equality of a lottery. For example, many healthcare registries employ a waiting list criterion to determine who will receive an available healthcare intervention. According to a waiting list criterion, we should give priority to patients who have spent the most time on a waiting list. Such an approach is impartial insofar as it selects patients on the basis of criteria relevant to the claims they make on resources. Specifically, it grants access to resources based on how long a patient has been waiting for treatment. And it is likely that those on the list have been sick for longer and therefore are in one respect *worst off*.⁹⁰

One problem with a waiting list criterion is that it presupposes that everyone has equal access to the waiting list. In reality this is not always the case.⁹¹ Patients from wealthier backgrounds with more ready access to medical services are likely to get on the waitlist sooner than those from disadvantaged backgrounds. It may be that a patient who is lower on the official wait list has in reality been waiting longer for treatment (i.e., they have been sick for longer). Furthermore, there are real world examples of celebrity patients being allowed to bypass a

⁹⁰ Herlitz 2018, 520-521.

⁹¹ See, for example, Bruce Pussell *et al.* "Access to the kidney transplant waiting list: a time for reflection". *Internal Medicine Journal* 42;4 (2012): 360-363.

waiting list to access scarce lifesaving resources.⁹² This provides some indication of the possibility of a waiting list being exploited.⁹³

Yet we should be careful about conflating the realms of ideal theory and practical implementation. All mechanisms for random selection would seem to be vulnerable to corruption when implemented in a real world context.⁹⁴ Our concern, however, is not with practical considerations. Rather, we are concerned with whether the framework can be said to allow for an impartial choice between candidates. In theory, a waiting list would allow for this. A waiting list would provide a reliable indication of how long each person has borne the burden of disease, provided that persons are added to the list as soon as they fall ill.

5.3: A first come, first served policy

Another criterion for allocation is a first-come, first served (FCFS) policy. On this approach, resources are allocated to those persons who present first at healthcare facilities. The person who first appears in a ward in need of treatment is allocated a bed and appropriate medical treatment; those who arrive later may miss out on treatment if no further resources are available. We should not remove treatment from a patient already in a ward in the event that another patient arrive who is also in need of treatment. Intensive Care Units (ICUs) are known to employ a FCFS criterion when rationing ventilators.⁹⁵ This approach to rationing is also sometimes employed in disaster response policies for healthcare. FCFS is said to be desirable

⁹² Judith Randal. "Mantle's transplant raises delicate issues about organ allocation". *Journal of the National Cancer Institute* 88;8 (1996): 484-485.

⁹³ This problem might also affect lotteries as well. I discuss this issue further in chapter 7.

⁹⁴ Cf. Henning 2015, 178-194.

⁹⁵ Leonard Fleck, Timothy Murphy. "First come, first served in the intensive care unit: always?". *Cambridge Quarterly of Healthcare Ethics* 27;1 (2018): 52-61.

insofar as it allows doctors to observe their fiduciary duties to the patients in their care.⁹⁶ Rather than having to wait to consider whether other patients require treatment, the doctor can act on the current health needs of patients and provide the necessary treatment. It is also, pragmatically, an easy criterion to implement. It does not require an extensive assessment of patients nor resort to some extra-medical means of prioritisation such as a lottery.

Yet critics have raised a number of objections to a FCFS policy. Some critics argue that we should allocate treatments to patients who have a significant capacity to benefit rather than patients who are first to present for treatment.⁹⁷ Furthermore, it is argued that, at least in some cases, it is permissible to withdraw life-support from patients who have a poor prognosis so that life-support can be provided to persons with a greater capacity to benefit.⁹⁸ That is, FCFS should not be seen as guaranteeing a patient a right to continued treatment. Furthermore, FCFS may favour those with better access to healthcare facilities, such as the “wealthy, powerful, and well-connected”.⁹⁹ Persons from poorer areas, and those in remote and rural areas, may not have the same degree of access to healthcare, and, as such, may be disadvantaged by a FCFS approach.

Yet our concern is with how these frameworks fare at the level of theory. And in theory, a FCFS approach, like a waiting list, would be a way to impartially allocate a resource between candidates. A FCFS policy would only be problematic if persons in the real world had unequal

⁹⁶ Kenneth Iserson, John Moskop. “Triage in medicine, part II: underlying values and principles”. *Annals of Emergency Medicine* 49;3 (2007): 282-287.

⁹⁷ Lluís Blanch *et al.* “Triage decisions for ICU admission: Report from the Task Force of the World Federation of Societies of Intensive and Critical Care Medicine”. *Journal of Critical Care* 36 (2016): 301-305.

⁹⁸ Fleck and Murphy 2018, 59-60; Robert Truog. “Triage in the ICU”. *The Hastings Center Report* 22;3 (1992): 13-17; Dominic Wilkinson, Julian Savulescu. “A costly separation between withdrawing and withholding treatment in intensive care”. *Bioethics* 28;3 (2014): 127-137.

⁹⁹ Persad, Wertheimer, Emanuel 2008, 424.

access healthcare facilities. In any case, it would be naive to suggest that a FCFS approach is uniquely vulnerable to corruption. As stated, any practical mechanism for patient selection is vulnerable to abuse. Indeed, ethicists such as Tyler John and Joseph Millum have argued convincingly that “in practice, lotteries share many of the disadvantages of queues”.¹⁰⁰ We should not, then, abandon FCFS as a selection mechanism merely on account of the risk of the system being exploited.

There is a question about whether it would be acceptable to withdraw treatment from patients once they have been admitted to a healthcare facility. It would take us too far afield to provide a comprehensive analysis of the ethics of withdrawal of life-support from patients. Yet it should be noted that one's position on this issue will be informed by one's view of the difference between the withdrawal and withholding of treatment.¹⁰¹ If one believes that the withdrawal of treatment raises distinct moral issues from the withholding of treatment, then one may object to the withdrawal of treatment from ICU patients for whom treatment is non-futile.

This should suffice for an initial overview of egalitarian criteria for the allocation of scarce interventions. In the later chapters of this thesis, I will consider when and how these criteria for rationing should be employed. Specifically, I will discuss how impartial criteria may provide guidance for the rationing of vital organs under conditions of scarcity.

Conclusion

In this chapter I have developed a conception of health need based on the concepts of health shortfall and urgency. I argued that these two criteria provide us with a means of identifying

¹⁰⁰ Tyler John, Joseph Millum. “First-come, first-served?”. *Ethics* (forthcoming).

¹⁰¹ Joachim Asscher. “The moral distinction between killing and letting die in medical cases”. *Bioethics* 22;5 (2008): 278-285.

which claimants are worst off and therefore should receive access to treatment or prophylaxis. I also suggested that capacity to benefit, while not constituting a fundamental part of health need, should function as a threshold for determining which persons are deemed eligible for treatment or prophylaxis. In the second part of this chapter, I discussed how a framework of need would apply to the allocation of life-saving medical interventions. I also considered how tie breaker criteria such as a lottery, waiting list and FCFS policy could function as an ethically defensible means for allocating resources among patients with equivalent needs.

The next three chapters will discuss approaches to healthcare rationing that focus on utility, age or desert. I will argue against the use of these alternative criteria for rationing. Our focus should be on the claims that people make on healthcare resources rather than on factors that are unrelated to people's health needs.

Chapter 4: Utilitarian approaches to the rationing of lifesaving healthcare interventions

We have just considered how a framework of respect for persons combined with a conception of health need applies to the allocation of lifesaving healthcare interventions. In this chapter, I turn to a consideration of an alternative approach to rationing, namely, a utilitarian approach to the rationing of lifesaving healthcare interventions. Utilitarian rationing frameworks have as their primary aim the maximisation of utility. Utility has been variously defined by philosophers as happiness,¹ pleasure,² wellbeing³ and preference satisfaction.⁴ In healthcare contexts, however, ethicists typically define utility in terms of concrete health outcomes. These include indices such as patient survival⁵ and quality of life,⁶ as well as the broader economic and social impacts of the provision of prophylaxis or treatment for population groups.⁷

¹ Cf. Bentham's conception of utilitarianism, namely, that "it is the greatest happiness of the greatest number that is the measure of right and wrong". See Jeremy Bentham. *A Comment on the Commentaries and a Fragment on Government*. (J. H. Burns and H. L. A. Hart (eds.)). London: Oxford University Press, 1977: 393.

² John Stuart Mill. *Utilitarianism*. Auckland: The Floating Press, 2009: 14.

³ Andrew Moore, Roger Crisp. "Welfarism in moral theory". *Australasian Association of Philosophy* 74; 4 (1996): 598-613.

⁴ Peter Singer. *Practical Ethics*. Cambridge: Cambridge University Press, 2011: 13-14.

⁵ Yoram Unguru *et al.* "An ethical framework for allocating scarce life-saving chemotherapy and supportive care drugs for childhood cancer. *Journal of the National Cancer Institute* 108;6 (2016): 1-7.

⁶ Alan Williams. "The value of QALYs". In Stephen Holland (ed.). *Arguing About Bioethics*. London: Routledge, 2012: 423.

⁷ Charles Ericsson *et al.* "Economic evaluation of immunization strategies". *Clinical Infectious Diseases* 35;3 (2002): 294-297.

Many theorists in the literature defend a utilitarian approach to rationing of lifesaving healthcare interventions.⁸ Some theorists argue that we should allocate lifesaving resources to the person or group who has the greatest capacity to benefit.⁹ Health benefit can be understood as an increase in life years, an increase in quality of life, or a combination of both of these indices. Other theorists argue that we should seek to save the most lives possible in our allocation of resources.¹⁰ This approach to allocation is particularly relevant when authorities are seeking to minimise social and economic impacts of a disaster.¹¹ Ethicists have also mooted the idea of rationing on the basis of economic and social utility.¹² On this view, patients should be prioritised based on the contribution they make to the community or the economic impact that they have.

Yet I will argue that a utilitarian framework for rationing fails to respect persons. Specifically, classical utilitarianism fails to take seriously the claims that people have on resources, and instead treats the maximisation of utility as the ultimate end of moral action. States of affairs are given precedence over persons and their claims, whereas respect requires that we distribute resources based on the moral claims that persons make on us.

This chapter deals with three versions of utilitarian rationing defended in the literature. The first approach seeks to save the most lives. The second approach seeks to maximise Quality

⁸ See, for example, Alan Williams. "Ethics and efficiency in the provision of health care". In: John Martin Bell, Susan Mendus (eds.) *Philosophy and Medical Welfare*. Cambridge University Press, New York 1988: 111-126.

⁹ Stein 2012, 47-56.

¹⁰ Marcel Verweij. "Moral principles for allocating scarce medical resources in an influenza pandemic". *Journal of Bioethical Inquiry* 6;2 (2009): 159-169.

¹¹ Cf. Douglas White *et al.* "Who should receive life support during a public health emergency? Using ethical principles to improve allocation decisions". *Annals of Internal Medicine* 150;2 (2009): 132-138.

¹² Alexander Friedman. "Rationing and social value judgements". *The American Journal of Bioethics* 11;7 (2011): 28-29.

Adjusted Life Years (QALYs) or life years saved. A third approach, what we might call a *social utilitarian approach to rationing*, takes as its object of concern social values such as economic productivity and the provision of essential services. Candidates for receiving a resource are thus selected on the basis of their social utility. In what follows I will critically analyse these frameworks, and will raise several objections to the manner in which they address healthcare resource allocation dilemmas. A unifying theme behind these objections is that utilitarianism seeks to maximise the utility gained from resources rather than respecting the claim that each person has on basic healthcare.

1. Situating utilitarianism in the context of resource allocation

Utilitarianism is a consequentialist ethical theory. Like all kinds of consequentialism, utilitarianism assumes that value resides solely in the consequences of actions, rather than in the other elements of moral action (such as the nature of the action itself, the character of the agent, or the agent's intention). Thus, if it is the case that we need to assess which of two actions is better or right, we should focus on the consequences alone, and not on other dimensions of moral action. What distinguishes utilitarianism as a kind of consequentialism is its concern with the promotion of utility. The aim of ethical action, according to utilitarianism, is to maximise utility.

Utilitarianism provides a philosophical alternative to egalitarianism when addressing the problem of resource scarcity. Resource scarcity gives rise to a basic question, namely, "whose needs should we meet when we cannot meet everyone's needs?". According to utilitarianism, the answer is that we should meet the needs of those to whom the greatest utility will accrue should they receive the resource. Rather than insisting on equality and sacrificing the utility of a resource, utilitarianism seeks to maximise the benefits gained from that resource. Consider, for example, a case where we must choose between providing lifesaving medical care to a person who is dying or providing minor pain relief for a million people who are otherwise in

perfect health.¹³ What would matter for the utilitarian in this case would be the size of the benefits that accrued to persons, not *who* the benefits accrued to.¹⁴

2. Utilitarianism and respect for persons

In this thesis I have been defending a framework for distribution that is based on respect for persons. According to this framework, our distributive decisions should attend to the individual claims that persons make on the resources in our control. Instead of focusing on states of affairs that maximise utility, we should focus on ensuring that persons are respected in our decision procedure for resource allocation. Specifically, we should prioritise individual claims based on their strength. Only a process like this acknowledges the moral standing of persons and their authority to make moral claims on us.¹⁵

This position is in direct conflict with a utilitarian framework that aims at the maximisation of wellbeing or some other good. A classical utilitarian framework does not give due attention to the moral claims that persons make on distribuenda.¹⁶ Rather, the relevant moral consideration is whether our decisions lead to states of affairs in which utility is maximised. As Ben Eggleston states,

¹³ Cf. Frances Kamm. "The choice between people: common sense, morality and doctors". *Bioethics* 1;3 (1987): 255-271.

¹⁴ One exception to this is prioritarianism. Prioritarianism is discussed in the final section of this chapter.

¹⁵ Cf. Stephen Darwall. *The Second-Person Standpoint: Morality, Respect, and Accountability*. London: Harvard University Press, 2006: 3-25.

¹⁶ See, for example, Amartya Sen, Bernard Williams. "Introduction". In: Amartya Sen and Bernard Williams (eds.). *Utilitarianism and Beyond*. London: Cambridge, 1982: 1–21; 4. Martha C. Nussbaum. *Creating Capabilities: The Human Development Approach*. Cambridge: Harvard University Press, 2011: 160; Ben Eggleston. "Consequentialism and respect: two strategies for justifying act utilitarianism". *Utilitas* (2019): 1-19; 10-12.

“The reason we are to promote any given individual’s well-being, according to act utilitarianism, is not that individuals have any moral significance, but that wellbeing has moral significance”.¹⁷

The moral worth of persons, then, is not of fundamental importance on a classical utilitarian framework. And while in some cases utilitarianism may distribute resources in a way that is consonant with respect for persons, the rationale that the utilitarian gives for such decisions will be grounded “in a deplorably incomplete set of relevant factors”.¹⁸ In fact, it would be based on one consideration alone: utility.

Some utilitarian theorists argue that utilitarianism’s concern with benefits rather than fairness is a *strength* rather than a *weakness*. For it could be said that egalitarian ethics leads us to adopt unacceptably wasteful and ultimate unjust modes of distribution.¹⁹ Utilitarianism, on the other hand, leads us to allocate resources in a manner that maximises utility and achieves the best outcome in a difficult situation. Indeed, some say that fairness *requires* that we concern ourselves with the maximisation of benefits. Thus, one commentator has remarked, “fairness, justice, and equity, in my view, require that we help those who can most benefit, as counseled by utilitarianism”.²⁰

It may be the case that utilitarianism leads to greater net benefits than a framework of respect for persons. Yet it still fails to take persons seriously. As Eggleston states,

¹⁷ Eggleston 2019, 10.

¹⁸ *Ibid.*, 13.

¹⁹ See, for example, Matthew Clayton. “Equality, justice and legitimacy in selection”. *Journal of Moral Philosophy* 9;1 (2012): 8-30; 18.

²⁰ Stein 2012, 50.

“...we are to maximize well-being in order to maximize the good, and individuals just happen to be affected because they are the bearers of well-being...act utilitarianism essentially treats individuals as mere receptacles of well-being”.²¹

On this interpretation, utilitarianism treats persons as *receptacles of utility* rather than having their intrinsic and fundamental worth recognised.²² A framework of respect for persons, in contrast, sees the individual claims of persons as the fundamental moral consideration for making distributive decisions.

There is, however, another interpretation of utilitarianism that is purportedly compatible with respect for persons. Specifically, some utilitarian theorists argue that utilitarianism respects persons by treating people equally and seeking to promote their wellbeing.²³ Utilitarianism weighs up the impact that different modes of distribution will have on wellbeing. On this view, “a well-being impact of a given size makes the same difference” to the goodness or badness of an action “regardless of which individual stands to incur it”.²⁴ It is not the case that the wellbeing of some individuals counts for more than that of others. Rather, utilitarianism ensures that all people are regarded “as equally important in the moral assessment of any given act”.²⁵ Utilitarianism need not, furthermore, be understood as a theory that puts states of affairs before persons. Rather, it can be understood as “a decision procedure that is intended to aggregate people’s preferences fairly”.²⁶ Fairness, on this view, is understood as entailing that we “regard[...] all [persons] as equally important in the moral assessment of any

²¹ Eggleston 2019, 10.

²² Richard Yetter Chappell. “Value receptacles”. *Nous* 49;2 (2015): 322-332.

²³ Eggleston 2019, 6.

²⁴ *Ibid.*, 7. See also Will Kymlicka. “Rawls on deontology and teleology”. *Philosophy & Public Affairs* 17;3 (1988): 173-190; 177.

²⁵ *Ibid.*

²⁶ Kymlicka 1988, 177.

given act". It involves finding a "fair compromise" between the preferences of different people.²⁷

Yet even this interpretation of utilitarianism is predicated on an impoverished conception of respect for persons. The basic thought is that we treat people respectfully by ensuring that interests are treated the same regardless of who they belong to.²⁸ Yet respect is, plausibly, an attitude that goes beyond giving equal consideration to how individuals stand to benefit or experience harm in a situation. Rather, respect for persons involves acknowledging the authority of others to make claims on us and the resources in our control.²⁹ We should consider the individual claims that agents make on us, and give priority to those persons whose claims are strongest. Respect, on this alternative conception, means making ourselves accountable to each individual and the claim that they make on assistance, rather than basing our decisions on considerations of equality or utility. As Darwall writes, the moral standing of others "can only be recognized second-personally, by making ourselves accountable to one another as equal free and rational agents".³⁰ We should, then, employ a criterion of need when assessing claims, and consider each claim individually rather than seeking to maximise utility.

Much more could be said about the tension between utilitarianism and respect for persons. Yet I do not want to pre-empt a close ethical analysis of the different ways in which utilitarianism might be applied to particular distributive scenarios. In what follows I will consider three varieties of utilitarianism that have been articulated in the resource allocation literature. For short, I will call these three positions *saving the most lives*, *health utility*, and *social utility*.

²⁷ John C. Harsanyi. "Cardinal Welfare, Individualistic Ethics, and Interpersonal Comparisons of Utility". *The Journal of Political Economy* 63 (1955): 309–21, 315.

²⁸ Eggleston 2019, 7.

²⁹ Darwall 2006, 137-138.

³⁰ *Ibid.*, 137.

3. Saving the most lives

One way in which a utilitarian framework can be applied to the allocation of lifesaving interventions is by seeking to save the greatest number of lives possible.³¹ That is, a utilitarian could seek to maximise the utility of *life*, understood in terms of number of lives saved. Life here should not be mistaken for the maximisation of life-years, as the saving of life years may not necessarily coincide with the goal of preventing the most deaths. Crucially, the object of saving lives is *numbers of persons saved, not life years gained*.

To understand how this framework would apply in practice, it is useful to consider a hypothetical scenario. Let's say we have to decide whether we save one person or five persons from certain death. Let's presume that there were two traffic accidents, and one person was injured in the first and five persons were injured in the second. All the accident victims have life-threatening injuries, and are alike in every other respect. We only have enough time, however, to reach one of the accident scenes. If we save the person on their own, the five persons in the other accident will die; if we save the five, the lone person will die.³² In this scenario, a utilitarian concerned with saving life would choose to save the five rather than the one. The only relevant consideration is the number of lives saved. And the value of the life of the one person who will not receive treatment is outweighed by the value of saving five lives.³³

³¹ See, for example, Marcel Verweij. "Moral principles for the allocation of scarce medical resources in an influenza pandemic". *Journal of Bioethical Inquiry* 6;2 (2009): 159-169.

³² Bognar and Kerstein 2010, 2.

³³ Cf. Peter Graham. "The numbers count". *Thought* 6;2 (2017): 129-134.

The conclusion reached by the utilitarian is not implausible. Many would agree that, absent special considerations, we should save the most lives rather than taking an egalitarian approach and, say, flipping a coin.³⁴ The attraction of the utilitarian position is even stronger when we consider cases with larger numbers. Rather than one versus five, it may be one versus a million. In the latter case, it seems difficult to argue that a concern for equality or fairness should take priority over saving a million lives.³⁵

Before continuing discussion, it is important to be clear that we are dealing with a hypothetical scenario that would be very unlikely to occur in the real world. It would be very rare that we had no other means of discriminating between persons except for the considerations pertaining to person-numbers.³⁶ In a real world scenario, we may, for example, be able to make a decision between persons based on their likelihood of survival. Furthermore, it is likely that in a real world crash scenario we would be time-pressured and lacking in personal information about the victims. In such a situation, it may be permissible in these circumstances to save the five on account of our lack of reliable information, rather than employing some time-consuming, egalitarian decision-procedure.

Yet I have defended a decision procedure that mandates that we consider the claims of individual persons rather than pursuing collective welfare or the maximisation of utility.³⁷

Respect requires that each person's claim receive due consideration in our distributive

³⁴ John Taurek. "Should the numbers count?". *Philosophy & Public Affairs* 6;4 (1977): 293-316; 294. See also Yishai Cohen. "Don't count on Taurek: vindicating the case for number counting". *Res Publica* 20;3 (2014): 245-261.

³⁵ Bognar and Kerstein 2010, 12.

³⁶ Rivlin makes a similar observation with respect to age as a tie-breaker criteria for rationing. He writes: "It is in fact not possible for two patients to have an identical condition, bearing in mind the differences between both of a medical and, just as importantly, a social kind, that might have a significant effect on the health and prognosis of individuals". See Michael Rivlin. "Why the fair innings argument is not persuasive". *BMC Medical Ethics* 1;1 (2000): 1-6; 4.

³⁷ Cf. Ronald Dworkin. *Taking Rights Seriously*. Cambridge, MA: Harvard University Press, 1977.

decisions, including situations where we must choose between lives. In the case above, then, if the claims of the one and the five are of equal strength, we should give equal value to saving the life of the one compared with saving the life of the five. Rather than seeking to save the most lives, we should use a random choice mechanism such as a lottery to decide who we will save. Only a procedure such as this would give equal importance to the claims of each individual in a way that is compatible with respect for the moral worth of persons.³⁸

Specifically, it seems that we should conduct a lottery that is weighted five out of six in favour of saving the group of five.³⁹ Each person deserves an equal stake in the lottery, as each person has an equally strong claim on our assistance.⁴⁰ Yet five of the persons are in one location, and so their chances of being saved are tied to each other. A choice to save one of the five has the incidental result that the other four persons in that location will also be saved. Importantly, a weighted lottery gives equal weight to the claims of each individual while accommodating to some extent for the intuition that we should save the five rather than the one. It softens the counterintuitive implications of decision-procedure based on an equal consideration of claims.

Most people, however, would not share this view. Even if there is a five out of six chance that we will save the five, that still leaves a small chance that we will save the one. And for many persons it would be unacceptable to save the one and let the five die. In the end, this is perhaps the main reason why many people are reluctant to adopt an approach that considers

³⁸ Cf. Bognar and Kerstein 2010, 3-7.

³⁹ Ben Saunders. "A defence of weighted lotteries in life saving cases". *Ethical Theory and Moral Practice* 12;3 (2009): 279-290. For a critique of this view, see Iwao Hirose. "Weighted lotteries in life and death cases". *Ratio* 20;1 (2007): 45-56. *In situ*, it may not be feasible to hold a weighted lottery. We are, however, considering a thought experiment rather than a real world scenario.

⁴⁰ John Broome argues that, in fact, a lottery provides a "surrogate satisfaction" of claims. See John Broome. "Fairness". *Proceedings of the Aristotelian Society* 91 (1990-1991): 87-101. See also Peter Stone. "Why lotteries are just". *The Journal of Political Philosophy* 15;3 (2007): 276-295; 287.

how each person's claim compares to every other person's claim. Such an approach might be seen as excessively preoccupied with the equal treatment of persons.⁴¹ It not only leads to a wasteful use of resources but also a greater loss of life than needs to be the case. Furthermore, one might take issue with the rationale behind holding a lottery. Commentators like Stone argue that lotteries "sanitise" the decision-making process by ensuring that "bad reasons [are] kept out of the decision".⁴² In response to Stone, however, one could argue that a desire to save the most lives is not a "bad reason" for prioritising the five over the one.

Yet suffice to say that, while it is not always intuitive, a framework of respect of persons ensures that individual claims are evaluated in a way that takes seriously the separateness of persons. Each individual claim is compared to all other individual claims, and a decision is made based on what each individual stands to lose.⁴³ Viewed from this perspective, "the numbers, in themselves, simply do not count".⁴⁴ It is irrelevant that a group of five will perish should the lottery lead us to save the one. In rare situations where we are dealing with persons with claims of equal strength, what matters is that due consideration be given to each individual claim.⁴⁵

There are some theorists who argue that we can aggregate (or add together) individual claims without violating our commitment to respecting persons. By aggregation, I have in mind the

⁴¹ When discussing an equal worth approach to saving lives, Kerstein and Bogner (2010, 6-7) state that this approach has "very little" to offer. For it conflicts with our intuitions in both scenarios where we must choose between a larger group and smaller group, and scenarios where we must choose between people of different ages.

⁴² Peter Stone. *The Luck of the Draw: The Role of Lotteries in Decision Making*. London: Oxford University Press, 2011: vii.

⁴³ Taurek 1977, 310.

⁴⁴ Ibid.

⁴⁵ Ibid.

adding together of the claims of individuals into a group claim.⁴⁶ Some theorists argue that we do not trivialise the claims of individuals by adding them together and weighing them against similar claims made by other persons.⁴⁷ Rather, it is sufficient to respect persons that we give their claim an appropriate weighting when deciding whose claims to meet. Thus, when we prioritise the five over the one, it is not the case that we ignore the badness of the harm sustained by the one person. Rather, “the harm remains regrettable, for that person’s sake, even if we ultimately have most reason to accept it for the sake of more greatly benefiting [others]”.⁴⁸ And so we can give due consideration to the claims of individual persons while adding together the claims that individuals make.

If one accepts this view – i.e., that aggregation is permissible in at least some circumstances – then it is permissible to prioritise the five over the one. For if we add together the claims of the five into a group claim, this collective claim will be stronger than the claim of the one.

While aggregation takes account of the claims of individual persons, it is nevertheless unacceptable for a theorist committed to engaging at a second-personal level with moral claims. An ethic of second-personal respect requires that we engage directly with – and make ourselves accountable to – each individual person making a claim on our assistance. This means that we should adopt a decision-procedure whereby we compare the claim made by each to that made by every other individual. Where we cannot consider each individual claim, we should take account of the claims that are tacit or “in force” in the particular context that

⁴⁶ Aggregation, in the most general sense of the term, refers to the adding together of morally relevant factors such as well-being, desire satisfaction, claims or reasons, into an objective value. For further discussion of this idea, see Iwao Hirose. *Moral Aggregation*. London: Oxford University Press, 2018: 23. See also, David Wasserman. “Aggregation and the moral relevance of context in health care decision-making”. In Rosamond Rhodes, Margaret Battin, Anita Silvers (eds.). *Medicine and Social Justice: Essays on the Distribution of Health Care*. New York: Oxford University Press 2002: 79-88.

⁴⁷ Alex Voorhoeve. “How should we aggregate competing claims?”. *Ethics* 125;1 (2014): 64-87.

⁴⁸ Richard Yetter Chappell “Value receptacles”. *Noûs* 49 (2015): 322–32.

we find ourselves in. Crucially, we should not treat claims as if they were interchangeable objects that can be added together or cancelled out. This would be to withdraw from second-personal discourse and treat claims as if they were just another “fact, norm or value” to be considered in our “own private deliberations”.⁴⁹ Aggregation treats people’s claims as if they were “utils” that can be added together, whereas the second-personal stance requires that we give individual consideration to moral claims issuing from distinct persons.⁵⁰

There is, furthermore, no compensation for the individual who loses out on an aggregative utilitarian calculus.⁵¹ Utilitarianism has been widely criticized for allowing the interests of the majority to take precedence over the interests of a minority. But this is precisely what a framework of respect for persons is trying to avoid.

We should refrain, then, from aggregating claims. Still, some theorists argue that there are ways of approaching the scenario that are non-aggregative but that nevertheless favour prioritising the five over the one.⁵² One option is to imagine that the individuals involved are behind a Rawlsian veil of ignorance.⁵³ That is, we should imagine that they do not know where they will end up in the scenario once the decision about prioritisation is made. They may end up in the one-person group, or they may end up in the five-person group. If we imagine individuals in this situation, it would seem that they would elect to prioritise the five over the one. For five out of the six individuals are saved. And there is a greater likelihood that they

⁴⁹ Darwall 2006, 137.

⁵⁰ Darwall 2006, 60. The term “util” refers to an individual unit of utility.

⁵¹ Alex Voorhoeve, Marc Fleurbaey. “Egalitarianism and the separateness of persons”. *Utilitas* 24 (2012): 381-398.

⁵² Iwao Hirose. “Saving the greater number without combining claims” *Analysis* 61;4 (Oct., 2001): 341-342.

⁵³ Carlos Soto. “The veil of ignorance and health resource allocation”. *Journal of Medicine and Philosophy* 37 (2012): 387-404.

themselves will be saved than if we were to prioritise the one. If we prioritise the one, they have only a one in six chance of surviving, whereas if we prioritise the five, they have a five in six chance of surviving. This approach does not rely on aggregation, but it still leads us to prioritise the five over the one.

The fundamental error with this way of approaching the scenario, however, is that it does not take into account the unique perspective of each concrete individual involved in the scenario, and the legitimate claim they have on lifesaving resources. This is precisely the kind of utilitarian impartiality, or decision-making from the “point of view of the universe”,⁵⁴ that an ethic of respect for persons is trying to avoid.⁵⁵ An ethic of respect for persons requires that we give due consideration to the claim of each individual *qua* an individual in the world. That is, we should attend to the complaints of individuals when *in situ*. As Kamm writes, “the point of view of each individual” is that “it is important that he rather than someone else lives”.⁵⁶ We should take the perspective of persons seriously in on our allocation decisions. We should, to quote Nagel, adopt an attitude of “individualised impartial concern”⁵⁷ that takes seriously the good of each individual person, and, crucially, does not attempt to combine or cancel out the interests of different agents in the name of the welfare of society (as some utilitarian theories of justice do).

All of which is to say, both the one and the five have a claim of equal strength on our resources. And we should seek to satisfy *both* the claim of the one individual and the claim of the five individuals; we should not ignore the claim of the one in satisfying the claim of the five. This is

⁵⁴ Henry Sidgwick. *The Methods of Ethics* (7th edn). London: MacMillan and Co., 1907: 382.

⁵⁵ *Ibid.*, 399.

⁵⁶ Kamm 1998, 259.

⁵⁷ Nagel 1991, 69; see also Thomas Nagel. “The justification for equality”. *Critica* 10;28 (1978): 3-31.

the reason why I advocated a lottery approach, rather than a decision-procedure that seeks to save the most lives. A save-the-most-lives approach either relies on aggregation and fails to take into account the unique perspective of each concrete individual involved in the scenario.⁵⁸ In doing so, it fails to show appropriate concern for the legitimate claim that each individual person has on lifesaving resources.

One complexity encountered is that public health decisions typically involve choices between large groups of persons. We often must make choices about which social and demographic groups we should prioritise. That is, we are already necessarily dealing with aggregated claims when we address problems at the level of population health as opposed to micro-allocation decisions.⁵⁹ In this situation, it seems that we must accept the aggregation of claims to some degree. For it is not practicable to take into account the unique claims of every individual involved.

Even in this context we should have a side-constraint based on respect built into our moral reasoning. This side-constraint is that we should never consider the size of different demographic groups when deciding who to prioritise. That is, we should not prioritise one demographic group over another simply because one group is larger than another.⁶⁰ This means that we should not adopt a save-the-most-lives approach when considering issues of population health. We should, rather, be sensitive to the levels of need of the different groups, and prioritise those groups that are most in need. Such an approach respects persons. A save-the-most-lives approach, in contrast, does not.

⁵⁸ Jens Timmermann. "The individualist lottery: how people count, but not their numbers". *Analysis* 64;2 (2004): 106-112; 109.

⁵⁹ Kristine Baeroe. "Public health ethics: resource allocation and the ethics of legitimacy". *Journal of Clinical Research and Bioethics* 4;1 (2013): 1-3.

⁶⁰ Lars Sandman, Erik Gustavsson. "The (ir)relevance of group size in health care priority setting: a reply to Juth". *Health Care Analysis* 25;1 (2015): 21-33.

4. Health utility

Saving the most lives is one way in which a utilitarian theorist might approach the rationing of lifesaving resources. Yet it is not the only way. A utilitarian might also focus on seeking the best health outcomes possible. Indeed, this will be a relevant measure for a utilitarian when we are dealing with interventions that not only save life but also may be used to increase long-term life expectancy or quality of life. What health outcomes mean in practice will differ depending on the health metric that theorists are using as a measure of utility. In this section I will focus in particular on two metrics commonly employed in healthcare resource allocation. These are, namely, QALY maximization and the maximisation of life years saved.

Quality Adjusted Life Years (QALYs) are a widely used measure of health outcomes from treatments. The metric has two key elements. These are a measure of life years gained as a result of treatment, and a measure of the quality of life that a person will experience in those life years. The latter dimension of treatment outcomes – the quality of life that a person will experience – is usually measured through a series of quality of life surveys completed by patients. This is then combined with an estimation of the additional life years that will be gained if one receives treatment.

In practice, QALY metrics are widely used to make decisions about the allocation of expensive therapies, and also to establish priorities for funding within healthcare systems. In some healthcare systems (such as the UK), the cost per QALY of a treatment is a key factor in determining whether that treatment will be publicly available.⁶¹ In the context of life-saving

⁶¹ Joy Ogden. "QALYs and their role in the NICE decision-making process". *Prescriber* April 2017, 41-43. Available from <https://onlinelibrary.wiley.com/doi/pdf/10.1002/psb.1562>.

interventions, significant discussion has taken place about the cost-per-QALY for treatment of patients receiving an intervention, particularly in cases where the patient receiving the treatment will require ongoing medical care subsequent to their initial intervention. For example, theorists have estimated the cost-per-QALY of patients who receive a liver transplant with a view to determining whether these interventions are indeed cost-effective, or whether healthcare funds should be directed elsewhere.⁶²

Many theorists would contend that QALYs are a relevant consideration when determining how we should allocate lifesaving interventions.⁶³ A QALY metric allows us to ensure that we attain optimal health outcomes in our allocation of scarce healthcare resources. It ensures that people who stand to gain the most in life extension and quality of life receive these interventions. Furthermore, QALYs allow us to account for the ongoing costs associated with treatment following the administration of a lifesaving intervention, and are therefore a very useful measure of cost-effectiveness.⁶⁴

Several ethicists and policy commentators have, however, expressed concern about frameworks that focus solely on QALYs. Such frameworks arguably do not allow us to account for the morally relevant facts regarding the situation of each individual vying for a lifesaving resource. As Sarah Whitehead and Shehzad Ali observe, “a QALY gained and lost is blind to health conditions and personal characteristics, including age, sex, severity of disease, level of deprivation, social role of individuals, area of residence (post code) and other individual

⁶² Fredrik Aberg. “Cost of a quality- adjusted life year in liver transplantation: The influence of the indication and the model for end- stage liver disease score”. *Liver Transplantation* 17;12 (2011): 1333-1343.

⁶³ See, for example, Stephen McConnell. “In defence of QALYs”. *Journal of Applied Philosophy* 11;1 (1994): 89-98.

⁶⁴ Peter Neumann, Joshua Cohen. “QALYs in 2018 – advantages and concerns”. *JAMA* 319;24 (2018): 2473-2474.

characteristics”.⁶⁵ Rather, the primary aim of measurements of QALYs and life years saved is the reductive achievement of the best health outcomes.⁶⁶

To some extent, QALY-based rationing raises problems akin to Robert Nozick’s famous utility monster thought experiment.⁶⁷ The utility monster, in Nozick’s scenario, is a creature that receives more utility (which in this case refers roughly to experiential wellbeing) from each unit of resources than any human could ever be capable of receiving. The utility monster, then, will always obtain more benefit from a resource than any human being. This is the case even when the utility monster is already very well off in terms of their experiential wellbeing. On a utilitarian framework, then, it seems that we will always be obliged to allocate resources to the monster, even when the monster is faring much better than everyone else. But this seems unfair.

A similar claim could be made about QALYs. For a QALY metric recommends that we prioritise the person or group that will gain the greatest number of QALYs from a treatment. Yet the metric makes no reference to how badly-off persons are. QALYs, then, may lead to inequitable modes of distribution. The metric leads us to prioritise the person with the greatest capacity to benefit, independent of how well-off they already are in comparison to others.

Theorists have observed in particular that QALY measurements disadvantage persons with disabilities. For persons with disabilities are statistically more likely to have lower life expectancy, lower health-related quality of life and lower capacity to benefit from treatment

⁶⁵ Sarah Whitehead, Shehzad Ali. “Health outcomes in economic evaluation: the QALY and utilities”. *British Medical Bulletin* 96;1 (2010): 5-21.

⁶⁶ These measurements are viewed by some to treat people as vessels-to-be-filled-with-utility. Cf. Gavin Mooney. ““Communitarian claims” as an ethical basis for allocating health care resources”. *Social Science and Medicine* 47;9 (1998): 1171-1180; 1177.

⁶⁷ Robert Nozick. *Anarchy, State, Utopia*. New York: Basic Books, 1971: 41.

than persons with no disabilities. As such, they are likely to end up scoring lower on QALY-measurements than other social groups. If QALY measurements are used as the basis for access to treatment, they will be less likely to receive access to medical care.⁶⁸

Rationing on the basis of QALYs is also biased against older persons. Persons who are older will typically stand to gain less from life extending treatments than persons who are younger. As such, they will end up scoring lower on health utility metrics and will in many cases receive lesser priority. It seems unfair, however, to systematically disqualify older populations from eligibility for treatment. At the very least, it seems that rationing based on QALYs should have certain side-constraints built into it that prevent the complete marginalisation of older populations. For example, a person's QALY score could be scaled depending on how old they are. This might ensure that the effects of natural ageing did not put older persons at a disadvantage.

Without modifications like this, a QALY-based framework fails to give appropriate consideration to the claims of persons; its focus is on capacity to benefit from treatment, not how badly a person is currently faring. It leads us to prioritise those patients who will gain the most from treatment, and it is not responsive to the severity and urgency of the health needs of individual patients.

Proponents of QALY-based rationing might concede that measurements of QALYs are insensitive to different forms of disadvantage. Nevertheless, one could argue that these measurements at least provide us with a consistent way to measure the benefits of treatment across populations, rather than buying into subjective assessments of need. For QALY

⁶⁸ Dan Brock, "Cost effectiveness and disability discrimination. *Economics and Philosophy* 25 (2009): 27-47; Mark Stein. "Utilitarianism and the disabled: distribution of life". *Social Theory and Practice* 27;4 (2001): 561-578.

surveys are a standardised, validated instrument with which we can gain an objective picture of how much different patients stand to benefit from treatment. QALY measurements are not confined to particular diseases; rather, they provide us with an objective way to measure the benefits of treatment for patients suffering from different diseases. In this sense, a QALY-based framework is arguably fairer than a needs-based approach, at least when considered as a systematic framework with which to approach rationing.⁶⁹

This response, however, presumes that measurements of need are subjective and incapable of acting as a standardised means of priority setting in healthcare. This claim is unfounded. Determinations of health shortfall are in fact more objective than measurements of quality of life. It is much easier to determine how advanced a person's cancer is than to accurately measure their subjective wellbeing. If anything, it is the proponent of the QALY-based approach that needs to respond to subjectivity objections.⁷⁰

Furthermore, the claim that QALY-based rationing is *egalitarian* is also deeply problematic. For the claim appears to be that equality is a function of the consistent application of a policy across a population. But the consistent application of a policy is perfectly compatible with that policy being unjust and unfair. What matters from the perspective of equality is not just the procedure with which public policy is implemented, but also the *content* of the policies. It would need to be shown that QALY-based rationing actually compensates for disadvantage and inequality in society. Yet this is precisely the issue – QALYs and life years are blind to social inequality.

⁶⁹ Joy Ogden. "QALYs and their role in the NICE decision-making process". *Prescriber* April 2017: 41-43; 42.

⁷⁰ For a discussion of some of the problems with current methods to calculate QALYs, see Paul Dolan. "Developing methods that really do value the 'Q' in QALY". *Health Economics, Policy and Law* 3;1 (2008): 69-77.

An alternative approach to maximising health outcomes is to ration on the basis of life years gained by patients as a result of an intervention. To do this, one needs to make an estimation of how many life years a patient or group of patients will gain if they receive an intervention. This approach is less common in a policy setting, though it has been proposed as a way of determining how we should allocate scarce resources such as vaccines.⁷¹ It is also commonly considered in moral philosophical discussions of resource allocation problems.⁷²

Life years saved is a more objective and equitable measure of health benefit than QALYs. Quality of life judgements will always involve some degree of subjectivity. There is subjectivity, for example, in assessing how a person's illness has affected their ability to undertake everyday tasks, and how treatment will improve their quality of life.⁷³ A life-years-saved approach, in contrast, only requires that we make a prediction about the life extension that a treatment will yield for a patient. A life-years-saved approach also does not discriminate against persons with disabilities (at least not in any direct way). A life year counts for the same regardless of whether it accrues to someone with a disability or someone who is able-bodied.

Furthermore, many theorists think that age matters, and that this requires that we take into account the life years saved as a result of treatment allocation. At least in situations where we need a tie-breaker principle, we should plausibly take into consideration the fact that one candidate is younger than another. For the younger candidate has more of their life still ahead of them. We can consider, for example, a hypothetical case involving a choice between two individuals, one 25 and the other 70, both of whom are in need of lifesaving treatment. If the

⁷¹ Mark A. Miller *et al.* "Prioritization of influenza pandemic vaccination to minimize years of life lost". *The Journal of Infectious Diseases* 198;3 (2008): 305–311.

⁷² See, for example, Richard Yetter Chappell. "Against 'saving lives': equal concern and differential impact". *Bioethics* 30;3 (2016): 159-164.

⁷³ Mohan Bala, Gary Zarkin. "Are QALYs an appropriate measure for valuing morbidity in acute diseases?". *Health Economics* 9 (2000): 177-180; 178.

70-year-old receives the treatment, they will live for a few more years. If the 25-year-old receives the treatment, they will live for several more decades. Both patients will die within days if they do not receive the treatment. It could be argued that the fact that the 25-year-old will gain more life years should make a difference in this case. The alternative would be to ignore age, and to give equal weighting to the claims of the two individuals. This approach is, nevertheless, counterintuitive; the intuitive response would be to give the younger person the drug, as they have a large portion of their life still ahead of them.⁷⁴

A life-years-saved metric would, nevertheless, systematically disadvantage older persons. Younger patients stand to gain more life years from lifesaving treatment, *ceteris paribus*, than older persons. Younger patients, then, would receive priority. One reason why this is problematic is that it could inadvertently fuel age-based prejudice in society.⁷⁵ If younger persons were routinely prioritised over older persons for treatment, this could reinforce the view that the lives of older persons *count for less* than that of younger persons. The topic of ageism will be discussed further in the next chapter.

At a deeper level, however, a life-years-saved metric does not give due consideration to the claim that each patient *qua* person has on our assistance. I have argued that a patient's entitlement to health care is predicated on the fact that they have the moral authority to make claims on us and the resources in our control. The strength of one's claim does not depend on factors such as capacity to benefit from treatment. Rather, it is based on the severity and urgency of one's health needs. We should not deprive a person of care simply on the basis that another patient has a greater capacity to benefit from treatment. Rather, our allocation of care should be based primarily on which patient is *most in need* of treatment.

⁷⁴ Bognar, Kerstein 2010, 2.

⁷⁵ J. Grimley Evans. "The case against". *BMJ: British Medical Journal* 314 (1997): 822-825.

In the case of the 25-year-old and the 70-year-old, we should give equal weight to the claim that each individual has on the resource. The health needs of the two individuals are equal. We should, then, use a procedure that recognises the equally strong claim that the candidates have on the resource. A lottery procedure or allocation on the basis of waiting time would be an appropriate method of distribution in this case.

This would be seen by many as an unacceptable position. Many people believe that age matters, and, as such, they would prioritise younger patients over the older ones. While in general we should try to meet people's basic needs, in tragic choice situations such as this, age should play a role in determining who receives the resource. In response to this criticism, however, I would make two observations. First, I am not endorsing a wasteful allocation of resources. I acknowledge that persons should have a minimum capacity to benefit from treatment. I would not advocate allocating a resource to a 70-year-old who has very little capacity to benefit. In the subsequent chapters of this thesis, I will argue for a threshold conception of capacity to benefit for organ transplantation, whereby persons must have a minimum capacity to benefit as agreed upon by the clinicians in consultation with the public.⁷⁶ Second – as mentioned earlier this chapter – it would in practice be rare to have to employ a lottery or waiting list as a method of allocation. In the vast majority of cases we can distinguish candidates on the basis of health need.

⁷⁶ The basic thought is that, while we should not ration on the basis of age, we would be warranted in withholding care from older persons if they had a negligible capacity to benefit from treatment. This would not amount to age-based rationing. Rather, our decisions would be based on a threshold of benefit that applied to all persons, regardless of their age. The idea of a benefit threshold will be discussed in detail in chapter 8.

Bognar and Kerstein offer a novel account of the compatibility of respect for persons with distribution on the basis of life years saved.⁷⁷ Respect for persons, on a classical Kantian conception, involves not treating people as a mere means.⁷⁸ In practice, this requires of us that we respect the autonomy of all persons affected by our actions. If we fail to respect their autonomy, we may be using them as a means without their consent, and this is unacceptable. But according to Bognar and Kerstein, it is permissible to choose patients who stand to gain the greatest number of life years from treatment, as such a decision does not involve using a person as a means to an end. We do not use an older patient as a means if we choose to give a younger patient priority access to treatment. Rather, “we [do not] intend the presence or participation of this person to contribute to the realization of our end”,⁷⁹ namely, the preservation of personhood through the promotion of life years. Our intention, rather, is focused solely on the younger patient.⁸⁰

This thesis has, however, defended an alternative conception of respect for persons. Bognar and Kerstein argue that respect for persons means not using persons as a means to an end. And this is certainly part of what it means to respect persons. There is a difference between, say, not giving someone a resource and actively using them as a means of obtaining a resource for others. Thus, Bognar and Kerstein say that it would be impermissible to operate on a healthy patient so as to obtain organs for five sick patients.

Yet, if we accept something like Darwall’s position, respect for persons also requires that we base our decisions on the individual claims that persons make on a resource. In chapter two,

⁷⁷ Bognar, Kerstein 2010, 12-20.

⁷⁸ Cf. Kant 1996, 429.

⁷⁹ *Ibid.*, 15.

⁸⁰ Bognar and Kerstein’s argument seems very similar to a double-effect justification of saving the younger patient. That is, the claim is that we do not intend for the older patient to experience harm. We merely foresee that the will experience harm should we allocate the resource to the younger patient.

I argued that this is an integral part of what it means to respect persons. We must acknowledge the authority of others to make claims on our assistance. Persons are not inanimate objects, but rather rational agents who have the capacity to engage in moral discourse with us and to make claims on us. Respect, then, involves recognising the claims of others and making ourselves accountable to these claims. It is insufficient to simply refrain from using people only as a means.

Bognar and Kerstein might argue that they *have* given due consideration to the claims made by the two persons in the scenario. The authors state that they “respect those who in the end perish by giving their preservation every bit as much weight as anyone else’s preservation in the process of determining how to proceed”.⁸¹ The authors note that “[a] person year of an individual we do not end up saving counts just as much in our calculations as a person year of someone we do end up saving”.⁸²

Attending to claims, however, involves more than just giving equal weight to the interests of persons. Rather, it means taking into account the specific content of the claims that persons make. People make claims of need on healthcare resources. We should, therefore, consider the degree to which patients are in need and evaluate their claims on this basis. In the hypothetical case under discussion, both patients will die within days if they do not receive the treatment. They therefore could be said to have an equally strong claim of need on the resource and be deserving of an equal chance of receiving lifesaving care.

5. Social utility

⁸¹ Bognar and Kerstein 2010, 18.

⁸² *Ibid.*, 18.

An evaluation of utilitarianism in the rationing of lifesaving resources would not be complete without a discussion of social utility. While very few theorists today openly defend rationing lifesaving interventions on the basis of one's social value, social utility is an idea that historically has been used to justify limiting access to lifesaving treatment for older persons, women, and those who are limited in their ability to contribute to society.⁸³ Furthermore, there are legitimate questions regarding the provision of treatment to healthcare workers and frontline staff when determining who should receive priority access to treatment in emergency scenarios. It is, therefore, appropriate to provide a principled analysis of the extent to which social utility can legitimately inform our resource allocation decisions.

We can begin by clarifying what is meant by the term *social utility*. In its most general sense, it refers to the social benefits of the provision of medical care to a person or group. These benefits may include anything from the economic contribution that the person or group is expected to make once they are restored to health, to their expected contributions in the spheres of politics, law, culture and so forth. It may even be the case that a person is valuable to society merely because of their social standing or because of the social contributions that they have made in the past.

Social utility is distinct from the concept of health utility or good health outcomes. For one, social utility is something that accrues to society, whereas health utility accrues to persons who are the recipients of treatment. Second, the goods that we would typically include in the category of social utility belong to social practices that are distinct from healthcare. For example, the goods of music, such as an aesthetically pleasing symphony, are different from the goods of healthcare, such as the health produced in persons suffering from severe illness.

⁸³ Cf. Jessica Du Toit, Joseph Millum. "Are indirect benefits relevant to health care allocation decisions?" *Journal of Medicine and Philosophy* 41;5 (2016): 540-557; Philip Rosoff. "Unpredictable drug shortages: an ethical framework for short-term rationing in hospitals". *The American Journal of Bioethics* 12;1 (2012): 1-9; 5.

The goods of music are produced in a different way, they are valued differently and they have distinct social significance to the goods of healthcare. If, therefore, it is the case that someone who receives healthcare goes on to produce beautiful music, we would call this an *indirect, non-health benefit*.⁸⁴ It arises as a result of someone being restored to health, but the benefit belongs to a completely different sphere of social life.

The ideas of social utility and health utility do, however, sometimes overlap.⁸⁵ For example, it may be the case that a person's social utility is precisely to produce the good of health within the healthcare system. Doctors, nurses, and other healthcare professionals fall within this category. More broadly, one might argue that persons involved in the provision of essential services such as law and order are also necessary if persons in healthcare are to carry out their work unimpeded. Without law and order, healthcare workers might sometimes be greatly hampered in the provision of care.

While a social utilitarian approach to resource allocation is not commonly defended, some theorists argue that we may have reason to provide special care to persons who occupy social roles of significant importance. For example, it may be the case that we have utilitarian reasons to provide better care for members of particular professions on account of the contribution they make to society. As Stone writes,

“Allocating a heart transplant to a brilliant surgeon or diplomat may ultimately save thousands of lives. This may provide a reason for making such an allocative decision even if the surgeon or diplomat did not have the strongest claim to the organ”.⁸⁶

⁸⁴ Du Toit, Millum 2016, 543-546; Kamm 1998, 258-259; Dan Brock. “Separate spheres and indirect benefits”. *Cost Effectiveness and Resource Allocation* 1;4 (2003): 1-12; 2-5.

⁸⁵ Brock 2003, 4-5.

⁸⁶ Stone 2007, 278, n.7.

This may be seen as unfair by some, but as Kasper Lippert-Rasmussen and Sigurd Lauridsen observe, “in some cases, it may be morally justified, all things considered, to do what is unfair”.⁸⁷ Essentially, considerations pertaining to utility may, all things considered, outweigh considerations pertaining to fairness.

An interesting comparison can be made between the scenario we are currently considering and 17th century philosopher William Godwin’s famous *Archbishop and the Chambermaid* thought experiment. In that scenario, readers are asked to consider who they would save from a burning room if they had to choose between an Archbishop called Fenelon – a renowned author and theologian who is about to write a masterful moral tale – and a common chambermaid. Godwin notes that in saving Fenelon we would “be promoting the benefit of thousands, who”, having read Fenelon’s tale, would “have been cured by the perusal of it of some error, vice and consequent unhappiness”.⁸⁸ Godwin argues that we should prioritise the Archbishop as he will contribute more to the betterment of humanity. The scenario is primarily meant to illustrate the importance of impartiality in decision making.⁸⁹ But in effect, Godwin is arguing in favour of rationing on the basis of social utility.⁹⁰

Critics of this approach to rationing, nevertheless, warn that social utility can have very negative implications for the moral equality of persons in society. We may, for example, be led to prioritise persons for treatment who are more economically productive than others. In doing so, we would not only unfairly disadvantage persons who are less economically productive,

⁸⁷ Kasper Lippert-Rasmussen, Sigurd Lauridsen. “Justice and the allocation of healthcare resources: should indirect, non-health effects count?”. *Medicine, Health Care and Philosophy* 13;3 (2010): 237-246; 242.

⁸⁸ William Godwin. *An Enquiry Concerning Political Justice*. Mark Philp (ed.). Oxford: Oxford University Press, 2013: book II; ch.II.

⁸⁹ Robert Lamb. “The foundations of Godwinian impartiality”. *Utilitas* 18;2 (2006): 134-153.

⁹⁰ Peter Singer. *One World Now: The Ethics of Globalisation*. New Haven: Yale University Press, 2016: 181-185.

but also would implicitly devalue their lives. As Dan Brock writes, such an approach assigns “worth to individuals and to individuals' lives on the basis of their social and instrumental value to others”.⁹¹ In other words, the approach treats persons only as a means and not also as an end. Yet an approach that respected the moral worth of persons would never only treat people as a means (at least, in so far as we take Kant’s Humanity Principle⁹² to be an indication of what it means to respect persons).

At a deeper level, rationing on the basis of social utility ignores the claims that persons make on healthcare resources. A social utilitarian approach to rationing does not base allocation on the strength of individual claims, but rather considers the utility that will accrue to society from different modes of distribution. Like other forms of utilitarianism, it seeks to ration health care based on an agent-neutral principle of utility. Yet this is contrary to the agent-relative perspective from which we should approach rationing. This thesis has defended an approach to rationing that bases allocation decisions on the claims that persons make on the resources in our control. We should make ourselves accountable to others by giving due consideration to the strength of the claims that they make on the resources in our control. As Darwall writes, “moral norms must be grounded from within the agent-relative/self-other standpoint of mutual respect”.⁹³

Even still, there are certain cases where it seems that consideration of a person’s social utility could legitimately inform our allocation decisions. One example is that of giving priority access

⁹¹ Brock 2003, 7.

⁹² Kant formulates his Humanity Principle as follows: “so act that you use humanity, whether in your own person or in the person of any other, always at the same time as an end, and never merely as a means”. Kant 1996, 429.

⁹³ Darwall 2006, 130.

to medical care for healthcare workers in a disaster scenario.⁹⁴ If we do not provide prophylaxis and treatment to medical staff involved in a disaster response, they will be unable to fulfil their role of providing healthcare to persons affected by the disaster. If this were the case, no one would receive adequate medical care. Thus, there is a strong case, then, for providing priority prophylaxis and treatment to healthcare workers in disaster response situations.

One need not invoke social utilitarianism, however, to justify the prioritisation of healthcare workers. There is a very real sense in which healthcare workers themselves have a grave need for prophylaxis when responding to an influenza pandemic. Granted, their need is primarily due to their professional role as frontline healthcare workers. But their need is no less real because of this. This is part of the claim that they have on healthcare resources, and it is something that we have a duty to take into account.⁹⁵

Need, importantly, is a much safer mechanism for patient selection than social utility. History shows how judgements of social utility can lead to “grossly prejudicial decisions, virtually eliminating certain groups of people from consideration for care”.⁹⁶ A criterion of need, on the other hand, is not susceptible to exploitation but rather provides a fair and impartial standard with which to assess patient claims.

6. Prioritarianism⁹⁷

⁹⁴ Marcel Verweij. “Moral principles for allocating scarce medical resources in an influenza pandemic”. *Journal of Bioethical Inquiry* 6;2 (2009): 159-169.

⁹⁵ It might even be argued that the satisfaction of the claims of patients depends on their being healthcare workers. Thus, giving priority to healthcare workers is presupposed (in some sense) by the (potential) claims of their patients.

⁹⁶ Rosoff 2012, 5.

⁹⁷ To be clear, I am only here discussing prioritarianism understood as a variant of utilitarianism. There are, however, other theories that receive the label prioritarianism that are not utilitarian. For example, non-consequentialist views that give priority to the worst off are sometimes labelled prioritarian. I do not necessarily have an objection to these views.

Finally, it is appropriate to consider prioritarian approaches to healthcare rationing, as prioritarianism is thought by some to be resistant to the common criticisms made of classical utilitarianism.⁹⁸ Prioritarianism is a variant of utilitarianism which combines a concern for utility with the intuition that benefitting people matters more the worse off those people are.⁹⁹ Derek Parfit summarised the fundamental assumption of prioritarianism as follows:

“benefiting people has more value the worse off those people are, the more of those people there are, and the greater the size of the benefit in question”.¹⁰⁰

The worst off are given *weighted priority* on this view. Benefits and the number of persons involved must also be taken into account. We should give priority to the worst off, however, in cases where we are dealing with groups that are equivalent in number and capacity to benefit.

Some prioritarians employ a threshold of wellbeing in their distributive framework so that the priority is only given to those whose lives are going badly.¹⁰¹ The thought is that an objective threshold of wellbeing can be used to distinguish a life that is going well from a life that is going badly. If a person or group falls below this threshold, then they deserve priority. A person or group that is above the threshold, in contrast, does not deserve priority – even if they are faring worse than another person or group. The threshold means that prioritarianism does not apply to cases where we are dealing with two or more persons or groups who are already faring very well. Thus, prioritarianism would not apply to a decision about offering fine wine to one of two very well-off groups of persons. Both of these groups are already very well-off, and so differences in wellbeing become irrelevant in determining how we should distribute

⁹⁸ Roger Crisp. "Equality, priority and compassion" *Ethics* 113;4 (2003): 745-763.

⁹⁹ Derek Parfit. "Equality and priority". *Ratio* 10;3 (1997): 202-221; 213.

¹⁰⁰ Crisp 2003, 756; Efrat Ram-Tiktin. "A decent minimum for everyone as a sufficiency of basic human functional capacities". *American Journal of Bioethics* 11;7 (2011): 24-25; 25.

¹⁰¹ Crisp 2003, 758.

resources.¹⁰² The threshold allows prioritarians to block counterintuitive applications of their theory.

One common objection made against utilitarianism is the so-called *irrelevant utilities objection*.¹⁰³ According to the irrelevant utilities objection, utilitarianism allows small benefits that accrue to a large group of well off persons to outweigh large benefits that accrue to a small group of very badly-off persons. This seems problematic, however, as benefits for persons who are very badly-off plausibly are more important than benefits for persons who are already well off. For example, it may be the case that, on a utilitarian framework, we should give priority to ten thousand people needing aspirin for a minor headache over one person needing cancer medication to survive. Yet it could be argued that the needs of the cancer patient trump the needs of persons with a headache, regardless of how numerous the latter are.

According to prioritarianism, however, persons with a minor headache would not meet the threshold of severity to be considered in our resource allocation calculus. Prioritarianism only comes into effect when we are dealing with persons who fall below a threshold of wellbeing. Only those with sufficiently serious ailments or injuries would count. Thus, prioritarians can avoid the irrelevant utilities objection.¹⁰⁴

Prioritarianism, then, is an attractive view. It considers a range of factors that many people think are morally relevant to the allocation of lifesaving healthcare resources. It takes into account health utility and people's capacity to benefit. But it also considers the number of

¹⁰² Ibid., 756-758.

¹⁰³ Kamm 1998, ch. 8.

¹⁰⁴ Ibid.

persons involved and how badly-off they are. Furthermore, prioritarianism does not give absolute priority to the worst off. Some see this as a virtue, for there is no risk of bottomless pit scenarios arising.¹⁰⁵ The spending of disproportionate amounts of money on one very sick person would eventually reach a point where it would be outweighed by the benefits of treating a larger group of sick patients.

Prioritarianism is also not dissimilar to a framework of need, as it relies on an objective standard of wellbeing to determine who is worse off. As Fleurbaey puts it, “people who are badly-off will have a great weight not because they are worse off than others, but just because they are badly-off”.¹⁰⁶ A prioritarian relies on an objective measure of wellbeing to determine priority, just as a basic needs theorist relies on an objective measure of need to determine who should receive a resource. Furthermore, the threshold of wellbeing upon which prioritarianism relies could be cashed out in terms of a threshold of basic need. On this view, a person would be deserving of priority insofar as they fell below a threshold of basic need.¹⁰⁷ Indeed, the use of a criterion of need would capture the insight articulated by Joseph Raz, that it is people’s objective needs that make them deserving of priority, not their level of wellbeing relative to others. Thus, Raz has written:

“what makes us care about various inequalities is not the inequality but the concern identified by the underlying principle. It is the hunger of the hungry, the need of the needy, the suffering of the ill, and so on”.¹⁰⁸

Thus, the reason why it matters that one person is worse off than another is because they are faring worse with respect to an objective measure of wellbeing (such as need).

¹⁰⁵ Cf. Juth 2015, 78.

¹⁰⁶ Mark Fleurbaey. “Equality versus priority: how relevant is the distinction?”. *Economics and Philosophy* 31;2 (2015): 203-217; 205.

¹⁰⁷ Cf. Michael Otsuka. “Prioritarianism and the measure of utility”. *The Journal of Political Philosophy* 23;1 (2015): 1-22; 21.

¹⁰⁸ Joseph Raz. *The Morality of Freedom* (Oxford: Oxford University Press, 1986): 240.

There are two key differences, nevertheless, between prioritarianism and an ethic of respect for persons. First, one of the axes on which prioritarianism assesses modes of distribution is the size of the benefits that are produced. That is, benefitting people counts for more, on the prioritarian framework, “the greater the size of the benefit in question”.¹⁰⁹ An ethic of respect for persons, in contrast, sees benefit as a threshold that persons must meet if they are to be considered to be in need. Benefit becomes irrelevant once people have been shown to meet this threshold. Beyond the minimum benefit threshold, it is the severity and urgency of the needs of persons that matters, rather than how much they stand to gain from receiving a healthcare resource.

Second, prioritarianism holds that the numbers *do* count when it comes to assessing the preferability of a mode of distribution. It matters for the prioritarian whether many or fewer persons stand to benefit from a mode of distribution. An ethic of respect for persons, in contrast, says that person-numbers should not count when determining how we should distribute resources. In situations where we must choose between a bigger and a smaller group, we should consider the individual complaints of persons rather than the aggregate claims of the groups.

In practice, prioritarianism and an ethic of respect for persons will often coincide in their conclusions about how resources should be distributed. For example, both of these frameworks would recommend prioritising a cancer patient in need of lifesaving medication over ten thousand persons in need of an aspirin to treat a minor headache. On the other hand, the two frameworks will diverge in cases where we are dealing with groups that are identical in their level of need but different in their size or capacity to benefit. In these situations,

¹⁰⁹ Ibid., 756.

prioritarianism would advise that we prioritise based on the size of each group and their capacity to benefit. A framework of respect for persons, in contrast, mandates that we attend to the individual claims that persons make on us rather than aggregating claims or seeking to maximise utility. Person-numbers and capacity to benefit are irrelevant.

The differences between prioritarianism and an ethic of respect for persons arise from a difference in the perspective from which the two positions view distribution. Prioritarianism, like other varieties of utilitarianism, approaches distribution from the perspective of an impartial spectator. It adopts the approach of Adam Smith, whereby we should “endeavour to examine our own conduct as we imagine any other fair and impartial spectator would examine it”.¹¹⁰ According to classical utilitarianism, the situation of each individual should be considered, and benefits should be given the same weight regardless of who they accrue to. Prioritarianism is unique insofar as it ascribes the virtue of compassion to the impartial spectator. Thus, the spectator

“...puts himself or herself into the shoes of all those affected and is concerned more to the extent that the individual in question is badly-off”.¹¹¹

And so prioritarianism gives weighted priority to benefits for those who are worse off. Crucially, however, prioritarianism retains a third-person view of distribution. It retains the view of spectator rather than someone engaging at a second-personal level with the claims of those persons who are affected by our distributive decisions.

An ethic of respect for persons, in contrast, requires that we engage at a second-personal level with the claims that persons make on our assistance. As Darwall states,

¹¹⁰ Adam Smith. *The Theory of the Moral Sentiments* (1759). D. D. Raphael and Alexander Macfie (ed.). (Oxford: Oxford University Press, 1976): 110.

¹¹¹ Crisp 2003, 756-757.

“we respect one another as equal persons...when we hold ourselves mutually accountable for complying with demands we make, and have the authority to make, of one another as equal free and rational agents”.¹¹²

What this means in practice is that we are accountable to each individual affected by our decisions when we distribute resources. We should not, then, abstract ourselves from a second-personal engagement with the claims that persons make. It is insufficient to make our utility calculation sensitive to the objective level of wellbeing of persons affected by our decisions. Rather, we should evaluate people’s claims individually and in a way that does justice to the content of their claim. In the context of lifesaving healthcare resources, these claims are claims of need. It is need rather than benefit that we should attend to when making these distributive decisions.

Conclusion

In this chapter I have considered three utilitarian approaches to the rationing of lifesaving healthcare resources. These are, namely, a save the most lives principle, a framework focused on capacity to benefit, and a social utilitarian approach to rationing. I argued that each of these approaches to rationing conflicts with an ethic of respect for persons. Each of these approaches fails to give due consideration to the claim that persons in need have on lifesaving healthcare resources. In contrast to utilitarian moral theorists, I argued that the claim that a person has on a resource is predicated on their moral standing as a practical reasoner, rather than their age or ability to benefit from treatment. I concluded this chapter with a discussion of prioritarian approaches to healthcare rationing. While prioritarianism is closer to a needs-based framework than strict utilitarianism, it still nevertheless prioritises patients on the basis

¹¹² Darwall 2004, 45.

of capacity to benefit. A framework of respect for persons, in contrast, prioritises patients on the basis of need alone.

In the next chapter, I will discuss an alternative approach to healthcare rationing that I call *lifetime egalitarianism*. This approach is directly opposed to rationing on the basis of utility. Lifetime egalitarianism mandates the allocation of resources to persons who are faring worse from the perspective of their entire lives. The lifetime egalitarian approach to rationing is similar to a framework of need insofar as it puts the interests of individual persons ahead of the maximisation of utility. It differs, nevertheless, from a framework of need insofar as it focuses on agents' whole lives rather than their current claims of need. I will consider why this difference in perspective is morally problematic when it comes to the allocation of lifesaving healthcare resources.

Chapter 5: Lifetime Egalitarianism and Age-Based Criteria for Rationing

There are two main kinds of argument that ethicists make for rationing healthcare on the basis of age. The first kind of argument is one that appeals to the utility of prioritising younger patients.¹ Younger patients will often have a greater capacity to benefit from healthcare than older patients. There is a utilitarian argument, then, for allocating treatment to younger patients, as they stand to benefit more than older patients. The second kind of argument is one that appeals to *fairness*, and, specifically, the entitlement of younger patients to have their *fair share* of healthcare resources. Older persons, by virtue of their age, have had more access to healthcare than younger persons. We should, then, prioritise the lives and needs of younger persons, as younger persons have enjoyed less access to healthcare than older persons.² In this chapter, I will focus specifically on fairness based arguments in favour of age-based rationing.

Some egalitarian frameworks for age-based rationing recommend the prioritisation of younger patients on the grounds of fairness. They are said to treat individuals fairly while at the same time accommodating for widely held intuitions about the need to prioritise younger persons.³ The basic thought is that, in situations of scarcity, we have no choice but to make a decision between saving the lives of older persons and saving the lives of younger persons. Younger persons have had less of relevant equalisanda than older persons, and as such have a

¹ See, for example, Mark A. Miller *et al.* "Prioritization of influenza pandemic vaccination to minimize years of life lost". *The Journal of Infectious Diseases* 198;3 (2008): 305–311; Leslie Scheunemann, Douglas White. "The ethics and reality of rationing in medicine". *Chest* 140;6 (2011): 1625-1632.

² For a summary of so-called *fair innings arguments* in favour of healthcare rationing, see Greg Bognar. "Fair innings". *Bioethics* 29;4 (2015): 251-261.

³ Cf. Kamm 1998, 247.

stronger claim on our resources. They therefore should be given priority access to these resources.

There is a fundamental tension, however, between what we might call a *lifetime egalitarian*⁴ approach to rationing and an ethic of respect for persons. Lifetime egalitarianism focuses on the distribution of lifetime equalisanda, whereas an ethic of respect for persons focuses on people's current health needs. Our primary consideration for assessing claims – according to an ethic of respect for persons – should be a person's immediate health needs, rather than their *need-over-a-lifetime*.⁵ In cases where we are unable to distinguish patients on the basis of their immediate health needs, one should utilise a random allocation mechanism, rather than relying on age-based considerations.

This chapter begins by introducing the idea of lifetime egalitarianism, *viz.*, the view that we should focus on agents' whole lives, rather than specific time segments in their lives, when deciding how to distribute equalisanda. It then considers what this view means in terms of the allocation of lifesaving healthcare interventions. Three objections to the lifetime egalitarianism are discussed. None of these objections constitute a knock-down criticism of lifetime egalitarianism, though they do raise worries about the practical implementation of the view. But there is still a fundamental tension between a lifetime egalitarian framework and respect for persons. The chapter concludes with a discussion of how lifetime egalitarianism precludes a consideration of the current claims that person make on healthcare resources.

1. Egalitarianism and lifetime egalitarianism

⁴ The term lifetime egalitarianism is taken from Ben Davies. "Fair innings and time-relative claims". *Bioethics* 30;6 (2016): 462-468.

⁵ Kamm argues that we should define need from a lifetime perspective rather than just focusing on a person's current needs. See Kamm 1998, 234.

Egalitarianism is a moral and political philosophical position that favours equality of some sort. As Richard Arneson observes, egalitarians hold that “people should get the same, or be treated the same, or be treated as equals, in some respect”.⁶ The dominant concern of egalitarians is perhaps best captured in the idea of *equality of condition*. That is, egalitarians seek to ensure equality in the conditions that characterise the existence of different people in society. This may entail, among other things, the pursuit of equality of welfare, resources, capabilities, opportunities, and rights.⁷

Egalitarians agree that equality of condition is a goal worthy of pursuit. Yet they disagree about how this goal should be realised in practice. There are a number of questions about how we should go about distributing equalisanda like resources, capabilities and opportunities. One particularly salient question concerns whether we should focus on present inequalities among individuals in society, or inequalities across the course of the lifetime of different persons in society. That is, we must determine whether we want to distribute the equalisanda evenly here and now, or whether the primary concern is that people get the same across the course of their lives. One’s distributive framework will differ significantly depending on one’s approach to this issue.

In recent years, many political philosophers have focused on a whole-of-life criterion for distribution. They argue that the *whole lives of persons*, rather than specific experiences or time slices in people’s lives, are the appropriate unit over which our egalitarian principles should operate. Nagel, for example, argues in his book *Equality and Partiality* that it is only

⁶ Richard Arneson. “Egalitarianism”. In: Edward N. Zalta (ed.). *The Stanford Encyclopedia of Philosophy* (Summer 2013 ed.). Stanford: Stanford University, 2013. Available from www.plato.stanford.edu/archives/sum2013/entries/egalitarianism/.

⁷ Cf. Gerald A. Cohen. “On the currency of egalitarian justice”. *Ethics* 99;4 (1989): 906-944.

when we consider a person’s life as a whole that we get a proper indication of how they have fared overall. Thus, he writes, “the [proper] subject of an egalitarian principle is not the distribution of particular rewards to individuals at some time, but the prospective quality of their lives as a whole, from birth to death”.⁸ We should, therefore, consider the lives of agents as a totality, and quantify over this totality when we are making decisions about distribution.⁹

Lifetime egalitarianism is an attractive view as it captures the widely shared intuition that what matters is not just equality at a particular point in time, but also equality between the whole lives of agents. That is, it is not just how a person is faring at present that matters, but rather how they fare across the course of their lives with respect to equalisanda like welfare, capabilities, opportunities and so forth.¹⁰ To illustrate this point, it is useful to consider the following hypothetical representation of the lifetime wellbeing of two agents.

Time	<i>t1</i>	<i>t2</i>	<i>t3</i>	<i>t4</i>	<i>Total wellbeing</i>
Individual 1 (wellbeing)	50	50	50	50	200
Individual 2 (wellbeing)	50	50	–	–	100

⁸ Nagel 1978, 3-31.

⁹ This term has been used by a number of political philosophers in recent years. See Iwao Hirose. “Intertemporal distributive judgement”. *Ethical Theory and Moral Practice* 8;4 (2005): 371-386; Kasper Lippert-Rasmussen. *Luck Egalitarianism*. London: Bloomsbury, 2015: 154; Ben Davies. “Fair innings and time relative claims”. *Bioethics* 30;6 (2016): 462-468.

¹⁰ Cf. David Velleman. “Wellbeing and time”. *Pacific Philosophical Quarterly* 72;1 (1991): 48-77.

In this graph, the t intervals represent 20 year segments of life. The numerical figure represents the wellbeing of each person during each of the 20 year segments. For argument's sake, let's say that individual 2 died a tragic and unexpected death at age 40 due to inadequate healthcare. This is why their t_3 and t_4 measures of wellbeing are blank.

It seems fair to say that individual 2's life has gone worse than individual 1, as individual 2 died a tragic death, whereas individual 1 lived to the age of 80. Furthermore, individual 1 had high wellbeing in the second half of their life, whereas individual 2 died prematurely and so had no life experiences subsequent to the age of 40. If we adopt the lens of time slice equality alone, however, we are unable to recognise the difference between the lives of individual 1 and 2. The persons are equal in welfare for all the time that they are both alive. Even though individual 2 died early, what matters from the perspective of time slice equality is their wellbeing at a particular time, not their lifetime wellbeing. The diminished lifetime wellbeing of individual 2 does not show up through this lens, so to speak. Time slice equality seems to miss something, then. Individual 1's life has gone better than individual 2, despite the fact that the two individuals experienced the same levels of wellbeing while alive.

What lifetime equality means in practice is that we should give priority to those persons who we think will fare worse across the course of their lives with respect to some equalisandum. And so we might give special access to university to persons from disadvantaged backgrounds so that they may have the same future level of opportunity as persons from wealthy backgrounds. Similarly, we might choose to give a significant amount of funding to palliative care for children with terminal illnesses. These children will die prematurely and will miss out on the life experiences that other children their age will eventually experience. Lifetime egalitarianism directs us to give special priority to these persons who will otherwise fare very poorly with respect to some lifetime equalisanda (be it wellbeing, opportunity, capabilities, or something else).

Lifetime egalitarianism is reflected in the way that many people think about current or simultaneous inequalities. Many would say that current inequalities may be acceptable provided that they are evened out in the future, or compensated for by the past. Thus, younger people in some jurisdictions contribute to public pension programs that fund pensions for older persons.¹¹ The implicit understanding in such systems is that those who are young now will eventually be eligible for a pension when they are older. One reason why publicly funded pension systems are seen as acceptable is because everyone ends up with roughly the same level of benefit over the course of their whole life.¹² This is one example of the willingness of persons to accept simultaneous inequality provided that equality is achieved across people's whole lives. There may be an inequality in the state benefits accessible by older people and those accessible to younger persons. But this inequality is accepted in light of the fact that younger persons will themselves be eligible for a pension when they are older.

Despite the broad applicability of lifetime egalitarianism in different domains of distributive justice, many believe that it is problematic when applied to the rationing of life saving healthcare resources.¹³ In what follows, I will consider how a lifetime egalitarian might ration scarce, lifesaving interventions. I will then consider some objections to this approach.

2. Lifetime egalitarianism and the allocation of lifesaving healthcare interventions

¹¹ Dennis McKerlie. *Justice Between the Young and the Old*. London: Oxford University Press, 2012: 4-5; Axel Gosseries, Lukas H. Meyer (eds.). *Intergenerational Justice*. Oxford: Oxford University Press, 2009.

¹² Ibid.

¹³ See, for example, Espen Gamlund. "What is so important about completing lives? A critique of the modified youngest first principle of scarce resource allocation". *Theoretical Medicine and Bioethics* 37;2 (2016): 113-128; Erik Nord. "Priority to the worst off: severity of current and future illness versus shortfall in lifetime health". In: Nir Eyal, Samia Hurst, Ole Norheim (eds.). *Inequalities in Health: Concepts, Measures, and Ethics*. London: Oxford University Press, 2013: 66-73.

In this section I consider what lifetime egalitarianism means in terms of the allocation of lifesaving healthcare interventions. Importantly, the way in which one applies a lifetime conception of equality to lifesaving treatment will differ depending on what one takes to be the currency of justice in healthcare. It is appropriate, therefore, to begin by considering what people take to be the equalisandum at stake in the distribution of lifesaving treatment. I will focus on the three most influential variants of lifetime egalitarianism in the resource allocation literature.

Some theorists argue that the relevant equalisandum for lifesaving treatment is *life years*. Lifesaving treatments are administered with the aim of producing additional life years in the lives of agents who face imminent death. Sometimes lifesaving resources may have additional effects, such as improving people's quality of life. By definition, however, lifesaving resources are characterised by their life-extending effects. It is life years, then, that we should focus on when deciding who should receive a lifesaving intervention. Brock is a proponent of this view. With regard to organ transplantation, he writes:

“In one sense we are distributing organs for transplant, but in a more general sense we are distributing additional life-years—that is the good that the transplant produces”.¹⁴

According to Brock, organs should be allocated on the basis of who will die the youngest should they not receive a transplant. For the youngest person has had the fewest life years out of those vying for an organ.

Other theorists argue that we should focus on *conscious time alive*, rather than life years, when determining how we should allocate lifesaving healthcare resources. Specifically,

¹⁴ Dan W. Brock. “Priority to the Worse Off in Health Care Resource Prioritization”. In Rosamond Rhodes, Margaret Battin, and Anita Silvers (eds.). *Medicine and Social Justice: Essays on the Distribution of Health Care* (New York: Oxford University Press, 2012): 155-163; 162.

Frances Kamm argues that we should distribute lifesaving resources (in particular, organs) on the basis of “adequate conscious time alive”.¹⁵ By adequate conscious life, Kamm is referring to “simple” or “medically adequate” conscious time alive.¹⁶ Admittedly, Kamm is quite vague about what this kind of conscious life looks like in practice. It appears that adequate conscious time alive is more than just *life-not-spent-in-a-coma*.¹⁷ Kamm, however, also wants to avoid an account of consciousness that is experientially thick and based on “more refined quality-of-life judgments”.¹⁸ Rather, she wishes to focus on “the concern that each person has simply for continuing on in adequate conscious life”. Kamm suggests that this is what people take to be most valuable in a situation where they are facing death.¹⁹ She states that the patient with the least adequate conscious time alive is the patient most in need.²⁰ She also suggests that the metric lines up roughly with age.²¹

Another equalisanda that some lifetime egalitarian theorists take to be constitutive of justice in lifesaving resource allocation is having the opportunity to live *a complete life*. The idea of a complete life is to some extent under-theorised – even by those scholars who defend it as a basis for healthcare rationing.²² I take *a complete life* to refer to the opportunity to experience all the milestones that characterise a typical full-life narrative. This includes the opportunity to

¹⁵ Kamm 1998, 234 -236.

¹⁶ Cf. Duff Waring. “Adequate conscious life and age-related need: F.M. Kamm’s approach to patient selection”. *Bioethics* 18;3 (2004): 234-248.

¹⁷ If adequate conscious time alive were equivalent to mere consciousness, then we would be unable to distinguish adequate consciousness from inadequate consciousness. Yet this is a distinction that Kamm wants to make. In light of this, adequate conscious time alive must be something more than just “anything above a coma”. See Waring 2004, 239-240.

¹⁸ *Ibid.*, 237-239; Kamm 1998, 234.

¹⁹ Kamm 1998, 236.

²⁰ *Ibid.*, 234.

²¹ *Ibid.*, 236.

²² Ruth Tallman. Valuing lives and allocating resources: a defense of the modified youngest first principle of scarce resource distribution. *Bioethics* 28;5 (2014): 207-213.

experience childhood, adolescence, professional life and family life. Lifesaving resources, according to proponents of the complete lives view, serve the purpose of allowing people to experience significant milestones when they would otherwise face death. Generally speaking, complete lives theorists say that a life is full or complete by approximately age 70 or 75. After this point, the continued existence of a person is of lesser importance. To be clear, complete lives theorists do not argue that people need to actually experience all the milestones that we might take to be constitutive of a complete life. What matters is rather that people have had the *opportunity* to experience these milestones (i.e., they have lived for a sufficient amount of time to have a family, a career, and so forth, even if in reality they never actually experience these milestones).

This should suffice for an overview of the currency of lifetime egalitarian justice in the rationing of lifesaving healthcare resources. There are other lifetime egalitarian theories that I have not discussed here – such as lifetime QALY prioritarianism,²³ or distribution on the basis of the level of access to healthcare that one has enjoyed during the course of one's life.²⁴ These approaches are less prominent in the literature, however, and are to some extent similar to the three theories discussed. Much of the subsequent discussion of this chapter will have import for these other lifetime egalitarian approaches as well.

We are now in a position to consider what a lifetime egalitarian framework means in practice for the allocation of lifesaving interventions. I will provide a brief overview of how the three equalisanda just discussed apply to the allocation of these scarce, lifesaving healthcare resources.

²³ Trygve Ottersen. Lifetime QALY prioritarianism in priority setting. *Journal of Medical Ethics* 39 2013: 175–180.

²⁴ Daniel Callahan. *Setting Limits: Medical Goals in an Ageing Society*. Washington, DC: Georgetown University Press, 2005: 22.

First, we can consider how the equalisandum of life years would apply to the allocation of lifesaving healthcare interventions. We can imagine a scenario where we are dealing with two persons – one 20 years old, the other 40 years old – who are vying for a lifesaving cancer drug. Let's say both persons will die in six months if they do not receive the resource in question. If they receive the resource, they will live for another 10 years.²⁵ A lifetime egalitarian concerned with the equal distribution of life years would prioritise the 20-year-old, for this person has had fewer years of life than the person who is 40. Even if the 20-year-old receives the resource and lives for another 10 years, they would still have had fewer life years than the 40-year-old. We should thus prioritise the younger patient over the older patient.

The allocation procedure is similar for theorists like Kamm who argue that lifesaving resources such as organs should be allocated to persons who have had the least adequate conscious time alive. Kamm notes that the amount of adequate conscious time alive will roughly correspond to a person's age, provided they haven't spent significant periods of their life in a less than adequate conscious state.²⁶ We should, then, prioritise the younger patient all things being equal. And so our approach to the previous scenario would be the same – we would prioritise the 20-year-old patient over the 40-year-old patient.

The third theory we considered was the complete lives approach to the rationing of lifesaving resources. To see how this framework applies in practice, we can consider a situation where the government must decide on which groups to prioritise during an influenza pandemic. Let's say we must choose between the 10 to 20 age bracket and the 80+ age bracket. Persons in

²⁵ Kamm argues that additional life years are of less utility to a person the older a person gets. That is, the value of additional life years decreases the older a person gets. For the sake of brevity, I will not engage with this account of the diminishing marginal utility of life years. For further information, see Kamm 1998, 237.

²⁶ Kamm 1998, 236.

the 10 to 20 age bracket have not had the same opportunity to experience the significant milestones of life. At most, they have experienced adolescence. The 80+ age bracket, in contrast, have experienced all the significant milestones of life. As such, presuming both groups have an equal chance of being infected by the virus, we should prioritise the younger group.

A complete lives framework will in general privilege persons who are younger over persons who are older. But there is an exception. Specifically, a complete lives framework places greater value on the lives of adolescents than infants and young children. Adolescents already have goals and projects in place in their lives, for example, while infants and very young children do not.²⁷ Furthermore, society has invested significantly in adolescents through schooling, social services and so forth.²⁸ As such, it is argued that we should prioritise adolescents over infants and very young children.²⁹

3. Objections to lifetime egalitarianism

In this section, I will outline three objections to lifetime egalitarian distributive frameworks. None of these objections constitutes a knock-down objection to lifetime egalitarianism, though questions are raised about the operationalisability of this framework for rationing. The first objection is that lifetime egalitarianism does not necessarily reduce inequality between patients. The other two objections focus on the arbitrariness of prioritising the young over the old, and the risk of ageism that comes with the introduction of age-based rationing into

²⁷ Tallman 2014, 207-213; 209-211.

²⁸ Persad, Wertheimer, Emanuel 2009, 428.

²⁹ This modification of the youngest first principle has been heavily criticised. See, for example, Kelsey Gipe, Samuel Kerstein. "Let us be fair to 5-year-olds: priority for the young in the allocation of scarce healthcare resources". *Public Health Ethics* 11;3 (2018): 325-335.

healthcare. Importantly, I do not want to trivialise the differences between the lifetime egalitarian theories just discussed. For the purpose of brevity, nevertheless, I will focus on objections that pertain to the common characteristics of different lifetime egalitarian frameworks for rationing.

The first objection we shall consider is the claim that lifetime egalitarianism does not reduce inequalities between patients (and may in fact compound them). This objection requires some explanation. The three varieties of lifetime egalitarianism that I have discussed all give priority to the person who will be worst off across the course of their whole life *if they do not receive the intervention in question*.³⁰ The focus is not on how much they will gain if they do receive the intervention, but rather how badly-off they will be (considering their life as an entirety) should they not receive it. For example, Brock's life years saved approach is focused on which patient would have the fewest life years *should they not receive the resource in question*. Thus, Brock writes, "The worse-off patient, other things equal, is the younger patient, who will have many fewer years of life if not treated than the older patient".³¹ Importantly, Brock believes it to be the case that we should prioritise the younger patient even when the older patient will gain more life years should they receive the resource in question. Thus he writes:

"...this priority to the young is not because they have a greater life expectancy and so greater expected benefit...Instead of looking forward to expected benefits, this application of priority to the worse (sic.) looks backward at how much of the good each will have had if not treated".³²

³⁰ By worst off, I mean worst off with respect to some equalisadum, be it life years, conscious time alive, or the opportunity to live a complete life.

³¹ Brock 2012, 162.

³² Ibid.

The same methodology is applied by Kamm and Persad *et al*/when making judgements about who is worse off with regard to relevant equalisanda. These theorists also *look backward* to evaluate who should receive treatment in the present.

A problem with this approach is that, in saving the group who has had the least of an equalisandum x , we may actually bring about a situation where there is more inequality rather than less in the distribution of x . To illustrate this, we can consider a scenario just outlined, involving two people vying for a scarce lifesaving resource. One of the persons is 20 and the other is 40. For argument's sake, let's say that if the 20-year-old receives the drug, their life expectancy will increase to 80. The 40-year-old, in contrast, will gain 10 extra life years should they receive the drug. Lifetime egalitarians would advise us to prioritise the 20-year-old. But if we prioritise the 20-year-old, we will create a situation where there is more inequality in life years than if we prioritised the older person. For the older person will die in six months, whereas the younger person will end up living till age 80. That will leave a difference in life years of 40 years between the two. This is much worse than giving the drug to the 40-year-old, who, even if they live for another 10 years, will only have lived for 30 years more than the younger patient.

Kamm herself acknowledges this potential objection to her view. Specifically, she states:

“...it is possible that helping the neediest results in more inequality than it alleviates, for in helping the person who would be worst off if not helped, we may do him so much good that he winds up overall much better than the person who was originally better off.”³³

³³ Kamm 1998, 250.

Yet she suggests that “it may [still] be right to help the worst off person”, i.e., the younger person.³⁴ Kamm does not, however, give reasons for why we should take this course of action. One possible justification would be that the younger patient also has the greater capacity to benefit, and that this is a relevant consideration as well. Egalitarians should not, however, concern themselves with utility. Their focus is on equality rather than utility.

A lifetime egalitarian theorist could, nevertheless, concede that we should prioritise the 40 year old patient while not undermining their broader lifetime egalitarian commitments. It would only involve a change in focus. Instead of focusing on who will be worse off if they do *not* receive the treatment, a lifetime egalitarian could instead focus on minimising inequality between the total lifespan of the patients *after the distribution of the resource*. If we give the resource to 20 year old, the overall inequality will be approximately 40 years. If we give the resource to the 40 year old, the overall inequality will be roughly 30 years. We should, then, prioritise the 40 year old. Or so a lifetime egalitarian might respond. This response preserves the core lifetime egalitarian commitment to overall equality, while focusing on post-treatment outcomes rather than how badly-off people will be should they not receive treatment. It allocates treatment in a way that most effectively minimises inequality.

This approach, however, raises certain epistemic difficulties for the lifetime egalitarian view. If the lifetime egalitarian theorist concedes that we should consider post-treatment prognosis when making allocation decisions – as they must in order to preserve their theory – it means that decisions about who to favour must rely on a super-capacity to predict medical outcomes. Sometimes it is very difficult to predict how a patient will fair post-operation. There is a significant margin of error, for example, when making survival predictions about persons who

³⁴ Ibid.

are in need of a transplant.³⁵ Granted, *all* medical ethics must deal with the uncertainty that arises in clinical prognostication. But we should not be naive about the difficulties inherent in deciding how we should distribute lifetime equalisanda. A lifetime egalitarian system would be difficult to operationalise in this respect.

The second objection to lifetime egalitarian approaches to rationing is that they are *arbitrary* in the way they distinguish between candidates. The notion of arbitrariness can here be interpreted in two ways: first, it could be claimed that the criteria used as a basis for the theory is arbitrary;³⁶ second, it could be said that the way in which these criteria are applied to real life situations is arbitrary. I will discuss these two versions of the objection in turn.

First, we should consider whether the criteria with which lifetime egalitarian theories distribute resources are arbitrary. We have considered three lifetime egalitarian criteria for rationing. These include life years; conscious time alive; and the milestones that characterise a complete life. It might be suggested that there is no justification for using any of these criteria to determine who is worse off. That is, it might be suggested that the proponents of lifetime egalitarianism have not given adequate justification for using their chosen criteria to ration healthcare. There are several equalisanda that we should be seeking to distribute evenly across the lives of different persons. We have no reason to single out one specific equalisandum as the sole criterion for justice in the allocation of lifesaving resources.

This objection seems to be a plausible criticism of Brock's *life years* approach to egalitarian rationing. For it seems that life years are a crude metric for determining how well one person's life has gone in comparison to others. Someone who is older than another person has not

³⁵ Kyong Don Yoo. "A machine learning approach using survival statistics to predict graft survival in kidney transplant recipients: a multicenter cohort study". *Scientific Reports* 7 (2017): 8904.

³⁶ Gipe and Kerstein 2018, 325-335.

necessarily had a better life than the younger person. For it seems that the *quality* of life years is relevant in addition to *quantity* of life years. Someone may be younger than someone else, and still be better off in terms of how their life has gone overall.³⁷ And so to give the resource to the younger patient will not necessarily mean that we have prioritised the worst-off patient. Proponents of the life years criterion for rationing would need to supply more of a justification as to why they believe life years track the overall wellbeing or opportunity experienced by a person.

The objection is less convincing as a criticism of the two other lifetime egalitarian theories I have discussed. It would seem that both Kamm and Persad, Emanuel and Wertheimer offer a principled justification for their criteria for rationing. Kamm focuses on adequate conscious time alive as she wishes to avoid making “refined quality of life judgements” that may be contentious. A focus on medically adequate conscious life allows one to sidestep debates about quality of life. Kamm also argues that, in a situation where people are facing imminent death, their primary concern is to “continu[e] on in adequate conscious life”.³⁸ As such, conscious time alive seems to be a justified criterion for allocating lifesaving healthcare interventions. Likewise, Persad, Emanuel and Wertheimer focus on one’s opportunity to experience life milestones for they believe this to be a good measure of a person’s overall level of opportunity throughout the course of their life. They acknowledge that in practice some people of a certain age may not have the same opportunities as others of the same age,³⁹ yet in general age lines up with particular stages on the complete life spectrum. As such, we are warranted in presuming, as a heuristic, that people of a certain age have had the opportunity to experience certain life milestones characteristic of their age (e.g., people in their 70s are

³⁷ Cf. David Velleman. “Wellbeing and time”. *Pacific Philosophical Quarterly* 77;1 (1990): 48-77.

³⁸ Kamm 1998, 236.

³⁹ Cf. Persad, Wertheimer and Emanuel 2008, 428.

probably coming to the end of their career, have grown-up children, and so on). All of which is to say that these theorists have not chosen their criteria for distribution at random. Rather, they focus on criteria that they argue track the overall wellbeing or opportunity in a person's life. It would seem unfair, then, to dismiss their frameworks as arbitrary.

This does not, however, mean that lifetime egalitarian criteria are the *right* criteria to employ when rationing lifesaving healthcare interventions. The observation is that Kamm and Persad *et al*'s lifetime egalitarian frameworks are internally consistent. When it comes to the allocation of lifesaving healthcare resources, however, this thesis has argued that we should take seriously the claims of need that persons make on resources. To do this, I have argued that we should seek both objective and universally acceptable criteria for allocating lifesaving resources. Need is something that is internal to the content of the claims that persons make on resources, while at the same time being an objective property of persons that is measurable through clinical observation. It is not clear, in contrast, that adequate conscious time alive or the idea of a complete life is objective and universally acceptable criterion for allocation. This consideration will be discussed further in the next section of this chapter.

We must also, however, consider whether there is arbitrariness in the way that lifetime egalitarian theorists apply their criteria to specific cases. It could be the case that we have sound justification for our criteria for allocation, and yet lack a reliable means by which to apply these criteria to real world cases. This criticism would not be entirely amiss. In practice, some lifetime egalitarian theorists argue that age can be used as a measure of how much wellbeing or opportunity a person has had. Persad, Emanuel and Wertheimer, for example, present a system for rationing that uses age as a measure of whether someone has lived a 'complete life'.⁴⁰ But age is an imperfect measure for whether someone has had the opportunity to live a

⁴⁰ Persad, Wertheimer, Emanuel 2008, 428-429.

complete life.⁴¹ While age may function as a useful measure, there are exceptions to the rule.⁴² As Gamlund notes, “it is unclear when exactly people are in the midst of a complete life”.⁴³ It may be the case, for example, that someone who is slightly older than someone else has not had the same level of opportunity to pass through the significant milestones that characterise a complete life.⁴⁴ The complete lives system, however, would not allow us to prioritise the older person in this case.

Age is functioning as a proxy for more a fundamental equalisandum in the case of the complete lives theory. That is, age is taken as a rough measure of whether a person has had the opportunity to experience significant life milestones. This proxy measure, however, could lead to ethically problematic results. Lifetime egalitarians must address the imprecision their proxy measures to track lifetime inequalities. Persad, Emanuel and Wertheimer would have to make exceptions to their age-based framework for rationing organs and vaccines. But it is not clear how this could be done without undermining the age-based framework for rationing that the complete lives system depends upon. The practical guidelines of a framework become meaningless if exceptions are constantly being made.

A third concern raised about lifetime egalitarian frameworks is that such frameworks may promote ageism in society. Essentially, it could be argued that we risk fuelling ageist prejudice in society if we systematically prioritise younger patients over older patients for access to

⁴¹ Samuel Kerstein, Greg Bognar. “Complete lives in the balance”. *The American Journal of Bioethics* 10;4 (2010): 37–45; 40.

⁴² Erik Nord. “Balancing relevant criteria in allocating scarce life-saving interventions”. *American Journal of Bioethics* 10;4 (2010): 56-58.

⁴³ Espen Gamlund. “Saving people from the harm of death”. In Espen Gamlund, Carl Solberg (eds.). *Saving People from the Harm of Death*. London: Oxford University Press, 2019: 76-90; 85.

⁴⁴ Richard Wagland. “A fair innings or a complete life: another attempt at an egalitarian justification of ageism”. In Harry Lesser. *Justice for Older People*. Leiden: Brill, 2012: 161-172; 168; Espen Gamlund. “What is so important about completing lives? A critique of the modified youngest first principle of scarce resource allocation”. *Theoretical Medicine and Bioethics* 37;2 (2016): 113-128.

lifesaving care. In response to proposals in the 1990s to integrate age-based rationing into NHS funding models, British doctor J. Grimley Evans warned that:

“We should not create, on the basis of age or any other characteristic over which individuals have no control, classes of Untermenschen whose lives and well being are deemed not worth spending money on”.⁴⁵

In the context of lifesaving healthcare interventions, the risk would be that we denigrate older persons in society. Even if it were the case that rationing took place while making clear that this was not an attack on the value of older persons, the public perception of such a policy would likely be that older persons “count for less” from an economic and social point of view. This is particularly the case because lifesaving interventions bear such a close relationship to questions of the value of life of different individuals.

This objection is perhaps best understood in the context of a *relational egalitarian* theory of distributive justice. Relational egalitarians hold that lifetime welfare is not all that matters, but rather that we should also consider the relationships and social dynamics between people in society when we are seeking to promote equality. As Elizabeth Anderson,⁴⁶ Martin O’Neill⁴⁷ and Anders Herlitz⁴⁸ observe, differential inequalities in things like access to healthcare can lead to domination and exploitation in society, stigmatizing differences in status, and relationships of servility and deferential behaviour. The issue is not (just) the levels of welfare faced by the agents but rather the power relations between different members of society. Stigma and status differences are objectionable for the relational egalitarian, regardless of how they fit within a broader, diachronic picture of individual welfare. The concern of relational

⁴⁵ J. Grimley Evans. “The rationing debate: rationing health care by age: the case against”. *BMJ: British Medical Journal* 314 (1997): 822-825.

⁴⁶ Elizabeth Anderson. “What is the point of equality?” *Ethics* 109 (1999): 287–337.

⁴⁷ Martin O’Neill. “What should egalitarians believe?” *Philosophy & Public Affairs* 36 (2008): 119–156.

⁴⁸ Herlitz 2018, 6.

egalitarians is, essentially, that age-based rationing could be the catalyst for relationships of domination, exploitation and stigmatisation. And it could be argued that widespread age-based rationing in healthcare would fuel such prejudice.⁴⁹

A lifetime egalitarian theorist could, however, argue that their framework does not imply any kind of stigma or denigration of older persons, but rather allows us to deal equitably with scarcity in lifesaving medical care. Persad *et al*, for example, argue that, rather than creating an underclass of “Untermensch”, their complete lives framework allows for a more fair and equitable decisions:

“...the complete lives system does not create “classes of Untermenschen whose lives and well being are deemed not worth spending money on”, but rather empowers us to decide fairly whom to save when genuine scarcity makes saving everyone impossible”.⁵⁰

The authors argue that, while aged based rationing may be problematic in some circumstances, there is no problem with basing rationing decisions on the principle that those who have not lived a complete life have stronger claims on scarce life-saving resources. This principle is broadly acceptable and does not involve any controversial moral commitments.

Essentially, a lifetime egalitarian could argue that there is no rational connection between age-based rationing on the one hand and social prejudice on the other. The justification for age-based rationing is not that the lives of older persons are of lesser value. Rather, the motivation is to ensure the just distribution of equalisanda across the course of agents’ whole lives. We

⁴⁹ Cf. Kamm 1998, 251. Kamm acknowledges that this is a “strong argument” for not focusing on overall equality but rather present inequalities.

⁵⁰ Persad, Emanuel, Wertheimer 2009, 429.

need not be committed to ageist prejudice if we ration resources in this way.⁵¹ On the contrary, we are being consistent in our egalitarianism if we adopt lifetime egalitarian policies for rationing.

The unpredictability of social dynamics should, however, still lead us to exercise caution in the introduction of age-based policies for rationing. While it may be the case that – when considered merely as a philosophical argument – an aged-based approach to rationing says nothing about the intrinsic value of older persons or the contribution they make to society, a “fair innings” health policy may, nevertheless, have unanticipated cultural effects that alter our perception of older members of the community.⁵² It might perhaps be the case that, even when health care policy makers mean no disrespect to older persons, they unintentionally undermine their already precarious status in a society preoccupied with independence and physiological strength.⁵³ A framework that draws attention to the “burden” that older persons place on the healthcare system may translate into a view that older persons are a burden on the human community itself.⁵⁴

Granted, arguments focused on cultural dynamics are difficult to evidence, but at the very least proponents of age-based rationing must provide critics with good reasons why their policies will not fuel ageist prejudice in society. In the end, lifetime egalitarians are proposing a change to the status quo, at least insofar as current allocation protocols generally do not ration care

⁵¹ Callahan argues that a “mature society” could “limit care for the aged...with no diminution of respect”. See Daniel Callahan. *Setting Limits: Medical Goals in an Ageing Society*. Washington: Georgetown University Press, 1995: 140-141.

⁵² Cf. Renee Fox, Judith Swazey. *Observing Bioethics*. New York: Oxford University Press, 2008: Ch.6; Daniel Callahan. “Bioethics: private choice and common good”. *The Hastings Centre Report* 24;3 (1994): 28-31; Anthony Fisher. “Fair innings? Against healthcare rationing in favour of the young over the elderly”. *Studies in Christian Ethics* 26;4 (2013): 431-450; 437.

⁵³ David Velleman. “Against the Right to Die”. In: *Beyond Price: Essays on Birth and Death* (New York: Open Books, 2015): 6.

⁵⁴ Cf. John Harris, Sadie Regmi. “Ageism and equality”. *Journal of Medical Ethics* 38 (2012): 263-266.

on the basis of age. And so it is arguably their task to convince policymakers that their policy will not undermine the status of older persons in society. Such well-evidenced reassurances have not been forthcoming in the literature to date, or so it might be argued.

This argument is ultimately not a knock-down objection against lifetime egalitarianism. Lifetime egalitarians could meet this challenge by providing case studies where age-based rationing policies have been introduced without a concomitant increase in age-based prejudice. Indeed, there are instances of age-based rationing of resources in organ allocation practices that might provide appropriate evidence to support the wider practice of age-based rationing. For example, it is now standard practice in the US to allocate kidneys from younger donors to younger patients on the basis that younger patients are more likely to experience the full benefits of a better transplant than older patients.⁵⁵

Precautions should, nevertheless, be taken to ensure that age-based rationing is not misconstrued by the public as a legitimization of ageist sentiment. It is plausible to say that social dynamics are unpredictable, and that this is something we should be wary of in any allocation policy that we adopt. With some studies suggesting growing ageist sentiment in society,⁵⁶ we should be mindful not to provide any further impetus to this trend. This is one reason why we should employ alternative tie-breaker criteria for rationing. Other rationing criteria do not come with the same risk of entrenching age-based prejudice in healthcare praxis. If health authorities ever did opt for age-based rationing criteria, it would be necessary to build in safeguards to ensure both proper practice and to head off unwanted cultural effects.

⁵⁵ United Network for Organ Sharing. "Two year analysis shows effects of kidney allocation system". Washington DC: UNOS, 2017. Available from <https://unos.org/news/two-year-analysis-shows-effects-of-kidney-allocation-system/>.

⁵⁶ Royal Society for Public Health. *The Old Age Question*. London: Royal Society for Public Health, 2018. Available from www.rsph.org.uk/uploads/assets/uploaded/010d3159-0d36-4707-ae54e29047c8e3a.pdf.

4. Lifetime egalitarianism, moral authority, and taking claims seriously

I have just discussed three objections to a lifetime egalitarian approach to healthcare rationing. None of these objections constitute a knock-down argument against the use of lifetime egalitarian criteria in the rationing of lifesaving healthcare interventions; they rather raise concerns about the operationalisability of these criteria in real world rationing contexts. But even if we were able to overcome these practical obstacles to implementation, there would still be a fundamental tension between lifetime egalitarianism and a framework that seeks to respect persons and take claims seriously. It is to this tension that I now turn.

It is instructive to consider how a lifetime egalitarian framework differs from a framework focused on the claims of need that persons make on lifesaving interventions. Perhaps the most salient difference is in how the two frameworks determine who is worst off. A lifetime egalitarian framework considers how well someone's total life is expected to go *overall*, with respect to some equalisandum. A framework of respect for persons, in contrast, considers how a person wants to be treated in the *present*. Theorists sometimes describe this distinction as a distinction between people's *diachronic interests*, or interests across the course of a lifetime, and their *synchronic interests*, or interests at particular moments of their life.⁵⁷

Importantly, lifetime egalitarians like Kamm agree that need is a relevant criterion for the distribution of lifesaving health care interventions. They understand the concept of need, however, in a completely different way to the manner in which it has been defined in this thesis. For Kamm, the basic constituent of need is "how overall badly-off in terms of adequate

⁵⁷ Wagland 2012, 12-11.

conscious life someone will be when he dies”.⁵⁸ That is, a person’s level of need is proportionate to the amount of conscious time alive they have experienced across the course of their whole lives. Thus, the person in need is not the person who is faring worst in terms of their current health, but rather the person who is expected to have the least adequate conscious time alive when they die.

Kamm discusses the view that we respect people by focusing on their current claims of need. At one point she summarises the position as follows:

“the thought is that we treat persons disrespectfully if we do not deal with their present pressing circumstances. It is wrong to detach ourselves sufficiently from the current complaints persons present to us to do an overall life calculation, or for that matter to do a future-oriented outcome calculation. This may be another aspect of the problem of moral distance. That is, we tend to think we should help the dying person on our doorstep if not the one in a foreign country. The here and now imposes itself”.⁵⁹

Kamm, however, ultimately rejects this view. Her primary reason for doing so seems to be that lifetime equality is what matters most. Even if persons do not receive needed lifesaving care, this does not matter provided they had more adequate conscious time alive than others.

A framework of respect for persons, in contrast, focuses on the current claims of need of persons. It acknowledges the fact that the claims of persons “impose themselves” on us, and are deserving of our consideration. Specifically, we have a duty to, where possible, respond to the claims that fellow practical reasoners make on us. To fail to do this constitutes a disrespect for persons (as Kamm herself alludes to). It is surprising that Kamm, who articulates

⁵⁸ Kamm 1998, 251.

⁵⁹ Kamm 1998, 250.

this position so clearly, does not provide an explicit account of why lifetime equality should take precedence over our moral duties to attend to people's claims of need.⁶⁰

Importantly, I am not arguing that lifetime equality is irrelevant to distributive justice. Plausibly, there are a plurality of values that are relevant to distributing resources in a way that is just.⁶¹ There may be other domains of justice where we should focus on equality across people's lives, such as the provision of welfare and educational opportunities to persons from disadvantaged backgrounds. We may even choose to allocate a significant amount of healthcare expenditure to research into pediatric illness, for it is even more tragic for a child to die from a terminal illness than someone who has lived a full life. When it comes to micro-allocation scenarios involving lifesaving resources, however, we should attend to each person's claim, and our primary criterion for assessing the strength of claims should be health need. People are entitled to have their claims taken seriously. Similarly, public health administrators distributing indivisible lifesaving resources at a macro-level should consider the claims that are "in-force" in a community. They should consider the sorts of claims that persons could reasonably make in the situation, despite the fact that we cannot engage in second-personal discourse with every individual candidate.

An interlocutor might press the point, however, and argue that there is no tension between respect for humanity and allocating resources to younger patients. Kamm, for example, argues that the prioritisation of younger patients is compatible with respect for humanity. She writes:

⁶⁰ My point is that, in this particular section of *Morality, Mortality*, Kamm does not provide an explicit response to the claim that we should seek to alleviate current inequalities, or focus on people's current health needs, rather than focusing on lifetime inequalities. For further information, see Kamm 1998, 250-251.

⁶¹ Rosamond Rhodes. "Medicine and contextual justice". *Cambridge Quarterly of Healthcare Ethics* 27 (2018): 228-249.

“Could it be that distributing resources so as to help the neediest treats humanity inappropriately in the older person, counting that humanity for nothing in him, and so radically alters our idea of what sort of being we as persons are, even when young?”⁶²

She proceeds to suggest that there is no disrespect for the humanity of older persons when we prioritise younger patients under conditions of scarcity. She writes:

“We do not, in general, think that giving something to someone who has not already had a great deal treats humanity in the less needy as nothing.”⁶³

The suggestion is that we do not demean or disrespect a less needy person by not giving them priority in situations where we cannot meet everyone’s needs. Nor do we devalue humanity considered in the abstract. Rather, respect for persons is compatible with providing for the needs of the person who is younger.

I do not disagree with Kamm’s contention that we should prioritise the patient most in need. Nor do I think that this approach somehow devalues humanity. On the contrary, we respect the moral authority of persons by taking their claims of need seriously. I do disagree, however, with Kamm’s claim that the patient most in need is, as a rule, the youngest. I have defined health need in terms of the severity of a patient’s illness and the urgency with which they require treatment. Someone’s needs do not become more important by virtue of the fact that they are younger. We should, rather, give equal weight to the health needs of patients of different ages.⁶⁴

⁶² Kamm 1998, 247.

⁶³ Ibid.

⁶⁴ Cf. Lasse Nielsen. “Taking health needs seriously: against a luck egalitarian approach to justice in health”. *Medicine, Health Care and Philosophy* 16 (2013): 407-416; 415. See also Harris 1987, 121; Erik Nord. “Concern for the worst off: fair innings versus severity”. *Social Science & Medicine* 60;2 (2005): 257-263; Larry Temkin. “Inequality and health”. In: Nir Eyal, Samia Hurst, Ole Norheim (eds.). *Inequalities in Health: Concepts, Measures, and Ethics*. London: Oxford University Press, 2013: 13-27; 25.

Conclusion

This chapter has critically evaluated several lifetime egalitarian frameworks for rationing lifesaving healthcare resources. Lifetime egalitarianism conflicts directly with an ethic of respect for persons. According to an ethic of respect for persons, we should consider the strength of a person's claim of need when determining whether they should receive access to a resource. This differs from lifetime egalitarian frameworks that focus principally on equalisanda such as life years, adequate conscious time alive, or the opportunity to live a complete life. In practice, then, we should refrain from rationing healthcare on the basis of age. Neither utilitarian nor fairness-based arguments in favour of age-based rationing are compatible with respect for persons. Even in situations where we must choose between patients with equivalent needs, we should refrain from employing a criterion of age to determine who receives a resource.

Another criterion for rationing proposed in recent literature has been personal responsibility for illness. The next chapter will discuss these proposals, and consider a series of objections to penalising persons with self-inflicted illnesses. Like age, personal responsibility for illness is a factor that does not vitiate a person's claim on basic healthcare. A person's claim on basic care is predicated on their status as a moral equal, not factors pertaining to an individual's life history and behaviour.

Chapter 6: Luck egalitarianism and responsibility-sensitive criteria for rationing lifesaving resources

This thesis has argued that the State should allocate lifesaving resources based on the strength of the claims of individual candidates. There are several theorists, however, who argue that we should take into account personal responsibility for illness when deciding how to allocate lifesaving resources.¹ Specifically, it is argued that patients who are responsible for their own illness should receive less priority when we are allocating resources. At the very least, responsibility should function as a tie-breaker criterion for the allocation of lifesaving resources, such that patients who are not responsible for their illness receive priority.

In this chapter I will discuss responsibility-sensitive criteria for allocation, situating them in the context of so-called *luck egalitarian* theories of distributive justice. I will offer an overview of how a responsibility criterion might be operationalised in healthcare resource allocation. I will also raise two objections to the application of these criteria to the allocation of scarce indivisible healthcare resources. First, we should not deprive people of basic healthcare, even if they are personally responsible for their illness. Second, responsibility-based criteria fail to take into account the nuances of the notion of personal responsibility, such as the fact that many of our health-related choices are heavily influenced by socio-economic factors. I conclude by arguing that, from the perspective of respect for persons, we have reason to resist

¹ See, for example, Walter Glannon. "Responsibility, alcoholism, and liver transplantation". *The Journal of Medicine and Philosophy* 23;1 (1998): 31–49; Eli Feiring. "Lifestyle, responsibility and justice". *Journal of Medical Ethics* 34 (2008): 33-36; Alena Buyx. "Personal responsibility for health as a rationing criterion: why we don't like it and why maybe we should". *Journal of Medical Ethics* 34 (2008): 871-874; Kristine Baerøe, Cornelius Cappelen. "Phase-dependent justification: the role of personal responsibility in fair healthcare". *Journal of Medical Ethics* 41 (2015): 836-840; Jasper Littmann. "How high is a high risk? Prioritising high risk individuals in an influenza pandemic". *Vaccine* 32;52 (2014): 7167-7170.

the use of a responsibility criterion for rationing – even as a tie-breaker in situations where we are dealing with individuals with equivalent needs.

1. Luck egalitarianism as a theory of justice

Much of this thesis has been concerned with egalitarian approaches to distributive justice. Importantly, there are a variety of egalitarian theories that can be applied to healthcare resource allocation. A simple version of egalitarianism might mandate that we distribute healthcare resources equally among members of society. This kind of egalitarianism does not, however, take into account the fact that some people need more healthcare resources than others, or that people have greater or lesser need for healthcare at different periods of their life. Someone who has a chronic illness, for example, may be more in need of medicines than someone who has very good health.² Alternatively, someone may have a greater need of healthcare in later life than when in adolescence and early adulthood. And so it seems that this simple version of egalitarianism is unsatisfactory as a framework for resource allocation.

An alternative egalitarian theory would be one which sought to give people equal opportunity to access healthcare should they need it.³ This is roughly equivalent to the framework of need that I have been expounding in this thesis. There are theorists, however, who object to this approach. One objection is that distribution on the basis of need is blind to the fact that some people are to blame for their own illnesses. That is, some people could be said to bear responsibility for their own poor state of health. In these situations, it could be argued that we

² Cf. Roger Crisp. "Equality, priority and compassion". *Ethics* 113 (2003): 745-763; 746. The concern I have raised is known as the 'levelling down objection' to simple egalitarianism.

³ Cf. Bernard Williams. "The idea of equality". In Peter Laslett, W. G. Runciman (eds.). *Philosophy, Politics, and Society*. Oxford: Basil Blackwell, 1963: 110-131.

should penalise people for their reckless behaviour. We might, for example, put them at the back of the queue for accessing treatments that are in high demand.

An egalitarian theory that takes this objection into account is *luck egalitarianism*. While the notion of luck egalitarianism has been variously interpreted by theorists, there are, nevertheless, a series of core commitments that underpin all luck egalitarian frameworks. While other egalitarians are concerned with seeking that everyone possess or have the same level of access to morally relevant goods or opportunities, luck egalitarians are primarily concerned with neutralising the impact of luck (or, at least, certain kinds of luck) on distribution. They differ from other egalitarians in that they give particular importance to the agency and responsibility of the agents involved. According to luck egalitarians, the responsibility that agents bear for their actions can be a reason to give greater or lesser importance to improving their current condition. As Arneson writes, for luck egalitarians, “the strength of any moral reasons there might be to alter the condition of some individual for the better or for the worse (if the latter, this is to be done for the sake of improving the condition of other individuals) can be amplified or dampened by some factor involving an assessment of individual responsibility”.⁴ In light of this, luck egalitarianism is sometimes labelled “responsibility-sensitive egalitarianism”.⁵

It can be difficult, nevertheless, to determine what counts as personal responsibility as opposed to luck.⁶ An agent may engage in risky behaviour, for example, because this is necessary to bring about a good outcome. Someone may, for example, take a job as a logging worker, despite the fact that this is a particularly dangerous line of work. The agent does not

⁴ Richard Arneson. “Luck egalitarianism interpreted and defended”. *Philosophical Topics* 32;1 (2004): 1-20; 2.

⁵ Carl Knight. “Luck egalitarianism”. *Philosophy Compass* 8;10 (2013): 924-934; 924.

⁶ Keith Hyams. “Why do risky choices justify inequality?”. *Diametros* 53 (2017): 60-74.

desire or will that a bad outcome occur as a result of risks that they have exposed themselves to at work. Rather, they have taken a risk as this is required to bring about a good outcome, such as paying the bills for their family or ending a long spell of unemployment. In these circumstances, it is unclear whether we should ascribe full blame to an agent should they incur harm. In these sorts of cases, luck egalitarians must have a means of distinguishing between different kinds of luck that may or may not be attributed to personal choice as opposed to factors outside of their control.

To this end, luck egalitarian thought has drawn heavily upon the distinction drawn by Ronald Dworkin between “option luck” and “brute luck”. In a 1981 essay entitled “What is equality?”, Dworkin wrote:

“I shall distinguish, at least for the moment, between two kinds of luck. Option luck is a matter of how deliberate and calculated gambles turn out – whether someone gains or loses through accepting an isolated risk he or she should have anticipated and might have declined. Brute luck is a matter of how risks fall out that are not in that sense deliberate gambles”.⁷

Roughly, luck egalitarians argue that brute luck is something outside of an agent's control, and is, therefore, something for which the state should seek to provide redress (at least in cases where we are dealing with *bad* brute luck). An example of bad brute luck might be someone who is born with a severe physical disability and as a result has limited mobility. Luck egalitarians would argue – and most people would agree – that the state has a responsibility to provide assistance for such persons. The State should, for example, ensure that buildings are accessible for persons with disabilities. Option luck, in contrast, refers to situations where an agent bears responsibility for the initial decision to take a risk, and, to this extent, the state

⁷ Ronald Dworkin. “What is equality? Part II: Equality of resources”. *Philosophy & Public Affairs* 10;4 (1981): 283-345; 293.

need not concern itself with providing redress for the bad consequences of the risks undertaken. An example of option luck would be someone who chose to invest their money in a startup business, knowing full well that the company may not take off. In this case, the agent in question has made a free choice to take a risk. The State is under no obligation to provide monetary compensation should the agent receive no return on their investment. For the decision to invest was one that the agent undertook freely and fully cognizant of the risks involved.

In circumstances where the State *should* provide redress for an agent's bad luck, there is debate among luck egalitarians about how this compensation should occur. Some egalitarians argue that there should be an initial levelling of the opportunity range of all agents.⁸ Others argue in favour of nullifying all differential effects of brute luck.⁹ It could be argued that the State should intervene throughout the lives of persons who experience the ongoing effects of bad brute luck. Yet suffice to say that almost all luck egalitarians see the effects of brute luck as something that the State should seek to neutralize.¹⁰

2. Luck egalitarianism and health care

Luck egalitarian principles have been applied in a variety of contexts, ranging from law and economics to education and healthcare. In the context of healthcare, proponents of luck egalitarianism consider the extent to which the government should compensate individuals

⁸ Cf. Peter Vallentyne. "Brute luck, option luck, and equality of initial opportunities". *Ethics* 112;3 (2002): 529-557.

⁹ Cf. G.A Cohen. *On the Currency of Egalitarian Justice and Other Essays in Political Philosophy*, Princeton, NJ: Princeton University Press, 2011: 5; 29.

¹⁰ For one exception, see Gideon Elford. "Equality of opportunity and other-affecting choice: why luck egalitarianism does not require brute luck equality". *Ethical Theory and Moral Practice* 16;1 (2013): 139-149.

who experience illness or disability as a result of circumstances outside of their control. They also explore the extent to which individuals should be held responsible for acting in ways that endanger their health. According to some luck egalitarians, there are circumstances under which we are forced to make difficult decisions in healthcare, and sometimes we will need to invoke notions of responsibility and desert to adjudicate between the competing claims of individuals.

One context in which luck egalitarian theories have been explored is that of healthcare financing. Public healthcare systems are typically financed in a way that does not discriminate between individuals on the basis of lifestyle and behaviour. But a luck egalitarian may be in favour of introducing criteria into healthcare financing that take account of the reckless behaviour that may increase one's likelihood of future illness or disability. Andreas Albertsen and Carl Knight,¹¹ for example, suggest that a public health system could ensure that individuals with illnesses associated with reckless behaviour could contribute through out-of-pocket expenses to covering the costs associated with their treatment. Alternatively, insurance policies could include premiums that reflect people's behaviour, and the government could tax activities and products that put the health of individuals at risk.¹²

This proposal is controversial.¹³ For one, it implies that we can make objective assessments of the lifestyle and behavioural profile of individuals in need of insurance or treatment. At a practical level, however, this would seem to be exceptionally difficult, if not impossible.¹⁴ It also

¹¹ Andreas Albertsen, Carl Knight. "A framework for luck egalitarianism in health and healthcare". *Journal of Medical Ethics* 41 (2015): 165-169.

¹² For an alternative approach, see Daniel Halliday. "The ethics of a smoking licence". *Journal of Medical Ethics* 42;5 (2016): 278-284.

¹³ See, for example, Anca Gheaus. "Solidarity, justice and unconditional access to healthcare". *Journal of Medical Ethics* 43;3 (2017): 177-181.

¹⁴ Cf. George Sher. "Real world luck egalitarianism". *Social Philosophy and Policy* 27;1 (2010): 218-232.

focuses attention on personal behaviour as the immediate cause of ill health while ignoring broader social factors at work that could arguably be more fundamental determinants of the health of an individual. But I do not wish to dwell extensively on the issues associated with luck egalitarian theories of healthcare financing. Rather, I want to focus on another application of luck egalitarianism in healthcare, namely, the allocation of indivisible resources under conditions of scarcity.

Luck egalitarianism and indivisible healthcare resources¹⁵

When deciding how to allocate scarce indivisible healthcare resources, it is sometimes not sufficient to rely purely on a criterion of health need. Strictly speaking, two patients may have the same level of medical need for a resource, and, as such, a criterion of need does not provide us with guidance about who to provide the resource to. Furthermore, some illnesses (such as liver failure) may in some cases have clear origins in the reckless lifestyle of individual patients. By definition, heavy alcohol consumption plays a major role in the development of Alcohol Related End Stage Liver Disease (ARESLED). Insofar as an individual can be held responsible for their heavy alcohol consumption – and this is a controversial topic – then they might be said to be at least partially responsible for their current poor health state. In situations such as these, some proponents of luck egalitarianism suggest that we should use a responsibility criterion to adjudicate between persons in need of lifesaving care. A principle of responsibility may, in extreme cases, function as a legitimate tiebreaker principle in our allocation of resources. All other things being equal, the individual who is not personally responsible for their pathology should receive priority over the individual who bears at least some responsibility for their poor health state. In the case of alcohol related liver disease,

¹⁵ By indivisible resources, I am referring to resources that cannot be divided among persons. Money is a divisible and fungible resource, whereas resources such as organ transplants are not.

individuals with ARESLD should, on at least some luck egalitarian frameworks, receive less priority for organ transplantation than an individual who has developed liver disease as result of factors outside of their control.

A series of clarifications are in order here. First, luck egalitarianism is, strictly speaking, silent on the question of who specifically should be held responsible for their health conditions. While it makes a generic distinction between option luck and brute luck, it does not specify, at an empirical level, which groups of persons fall into the category of option luck and which fall into brute luck. This is an important caveat, as it draws our attention to the fact that some luck egalitarians are not as harsh in their assessments of responsibility and individual health as might initially be supposed. Albersen and Knight, for example, state that “it is not an integral part of luck egalitarianism to claim that [patients with ARESLD are] in fact responsible for their condition”.¹⁶ Second, luck egalitarians may in fact recognise that an individual is responsible for their current poor health state and nevertheless not impose penalties on that individual. Some luck egalitarians argue, for example, that a desert principle should be constrained by the moral imperative to provide for the basic needs of human beings.¹⁷ As such, they believe that introducing penalties for the development of health-related pathologies is unfair as it would deprive an individual of basic healthcare that all persons are entitled to regardless of the responsibility they bear for their own health state.

These caveats notwithstanding, there still seems to be a series of issues associated with the desert criterion – *viz.*, that individuals should be held responsible for their largely self-induced illnesses – that is built into at least some luck egalitarian theories of healthcare resource

¹⁶ Albersen and Knight 2015, 167.

¹⁷ Shlomi Segall. *Health, Luck, and Justice*. Princeton: Princeton University Press, 2010: 68-73.

allocation.¹⁸ The next section will focus on variants of luck egalitarianism that do not adopt a basic needs side-constraint. By a basic needs side-constraint, I have in mind the idea that there are certain needs that are sufficiently serious and urgent that they should be met regardless of a patient's responsibility for their own illness. I will focus on varieties of luck egalitarianism that *do not* have this side-constraint.

I am, nevertheless, sceptical about attempts to introduce side-constraints into luck egalitarian accounts of justice. Since luck egalitarianism is largely motivated by neutralizing luck, proponents of the theory are forced, I think, to make some distinctions regarding the allocation of resources to those who “deserve” their ill health and those that do not. To some extent the introduction of humanitarian side-constraints into luck egalitarian theory is in tension with the commitment of many luck egalitarians to *not* nullify the differential effects of option luck.¹⁹ For it is precisely in areas like health, education and employment – domains of basic human need – that the effects of our reckless choices often manifest. As such, one wonders whether it is legitimate to call luck egalitarianism a *theory* of distributive justice when considerations of luck are reduced to playing a subordinate role to a principle of need. It seems that in this case, responsibility has been reduced to functioning as just one ethical consideration among others.²⁰ I will return to this topic in the final section of this chapter.

3. Objections to a luck egalitarian criterion for scarce resource allocation

¹⁸ Cf. Eric Rakowski. *Equal Justice*. London: Oxford University Press, 1991: 73-88.

¹⁹ Lasse Nielsen, David Vestergaard Axelsen. “Three strikes out: objections to Shlomi Segall’s luck egalitarian justice in health”. *Ethical Perspectives* 19;2 (2012): 307-316.

²⁰ Segall 2010, 64-68. Segall’s own account of luck egalitarianism allows other considerations of justice to trump a responsibility principle. Yet in doing so, it seems that he undermines the central role that considerations of responsibility and equality should play in a luck egalitarian theory of distributive justice.

For argument's sake, let's presume that our luck egalitarian interlocutor believes that a desert criterion can be used to ration indivisible resources such as vaccines, organs, ventilators, and the like. Let's suppose that they believe that obese persons with bad dietary habits, smokers, alcoholics and so forth should in many cases be *deprioritised* for treatment. They believe that no one should be "rewarded" for their inherently risky behaviour.²¹ I will here outline two objections to this view.

3.1: Difficulties surrounding attributions of responsibility

The first of these objections concerns the problems with ascribing responsibility to an agent for their own illness (and, furthermore, the difficulty of ascribing blame for addictions). While personal choice seems to play at least some role in the development of illness, recent literature suggests that genetics and social factors are the key predictors of the development of disease (consider, for example, obesity) and the adoption of bad lifestyle habits conducive to disease (such as smoking).²² Insofar as one's genetics and other environmental factors play a pivotal role in the development of obesity, and, to a lesser extent, the adoption of habits such as smoking, it seems problematic to rely heavily on ascriptions of personal responsibility when assessing whether these individuals should receive access to scarce resources. The reality is that the etiology of disease includes a complex matrix of genetic, social, cultural and economic factors; this fact to some extent lessens the force of any attempt to ascribe personal responsibility to persons with lifestyle-related diseases.

²¹ See, for example, Jasper Littmann. "How high is a high risk? Prioritising high-risk individuals in an influenza pandemic". *Vaccine* 32 (2014): 7167–7170; Andres Albertsen. "Drinking in the last chance saloon: luck egalitarianism, alcohol consumption, and the organ transplant waiting list". *Medicine, Health Care and Philosophy* 19;2 (2016): 325-338.

²² Michael Marmot, Richard Wilkinson (eds.). *The Social Determinants of Health* (2nd ed.). London: Oxford University Press, 2005.

Michael Marmot, for example, has written extensively about the relationship between a person's position in a social hierarchy and the decisions they make that affect their health.²³ Specifically, Marmot challenges the idea that bad lifestyle choices (such as unhealthy eating, smoking, and lack of exercise) are free and rational decisions that people make. He argues that social factors – in particular, a person's social class – have a profound influence on whether someone chooses to engage in unhealthy behaviours. Marmot writes:

“If people choose freely, why does smoking follow a social gradient? It cannot be a coincidence that you are more likely to choose to smoke if you are low status than if you are high... smoking does not follow a social gradient because of ignorance... it is almost as if people know what is in the health warnings, but the degree of attention they pay to these warnings increases as they go up the social scale”.²⁴

It is not just people's health, then, that is affected by social factors. Rather, the very choices that lead to bad health are conditioned by a person's position in society.

Even if it were the case that we can blame individuals personally for the presence of risk factors (such as obesity or heavy smoking) there is still a question about the relationship between blame for one's current lifestyle and any diseases that might arise as a result. While a person with a bad diet or a habit of smoking might know that they are at greater risk of sickness and disease, they do not necessarily will or desire that they develop these illnesses or diseases. And there is arguably a difference between doing *y* when one knows that *x* will necessarily occur as result, and doing *y* when one knows that there is a significant chance

²³ Michael Marmot. *The Status Syndrome*. London: MacMillan, 2004. See also Michael Marmot. “Status syndrome”. *Significance* 1;4 (2004): 150-154.

²⁴ *Ibid.*, 45-46.

(but by no means a 100% probability) of x occurring as result.²⁵ In light of this, we should not blame a person if they develop lifestyle-related disease.

3.2: Harshness

Even if we can blame individuals for their irresponsible lifestyles, this does not mean that we have a right to deprive people of basic healthcare. Several commentators argue, *contra* luck egalitarianism, that basic healthcare should be provided to people regardless of their past lifestyle or reckless behaviour.²⁶ We might consider the commonly discussed example of the motorcyclist who in a rare error of judgement decides to go out riding one day without a helmet on (they are usually quite dutiful in wearing their helmet). During the trip, the motorcyclist takes a turn too fast and ends up crashing into a guardrail. He sustains severe head injuries that require immediate medical attention. For argument's sake, let's say that the motorcyclist can be held responsible for their head injuries – the injuries would not have occurred if they were wearing a helmet. Even still, it seems that we should give the motorcyclist the necessary medical care, even if it comes at a considerable cost. But strict luck egalitarianism supposes that “the faulty driver has no claim of justice to ... medical care”.²⁷ A luck egalitarian theorist (of the sort that I am concerned with) would suppose that the individual involved bears responsibility for the actions and so in theory they need not be provided with appropriate healthcare. Granted, in practice there may be other reasons to provide the person with care, such as the social utility of the individual, or some supererogatory conception of beneficence

²⁵ Cf. Rik Peels. “A modal solution to the problem of moral luck”. *American Philosophical Quarterly* 52; 1 (2015): 73-88.

²⁶ Lasse Nielsen. “Taking health needs seriously: against a luck egalitarian approach to justice in health”. *Medicine, Health Care and Philosophy* 16;3 (2013): 407-416; Yvonne Denier. “On personal responsibility and the human right to healthcare”. *Cambridge Quarterly of Healthcare Ethics* 14 (2005): 224-234.

²⁷ Elizabeth Anderson. “What is the point of equality?” *Ethics* 109 (1999):287-337; 296.

adopted by healthcare providers.²⁸ Even still, the theoretical objection remains, namely, that luck egalitarianism *in se* seems unduly harsh and unforgiving.

At least some varieties of luck egalitarianism, furthermore, do not explicitly accommodate for the weakening of one's responsibility for past actions over time. Many luck egalitarians do not engage with the question of whether blame diminishes over time; rather, the presumption seems to be that one must live with the effects of one's choices, regardless of how much time has elapsed or how much the individual has changed.²⁹ The view can be formulated as follows: Insofar as an agent makes a bad choice at time t_1 , they will be held responsible for the consequences of that choice at point t_2 , no matter how much time has elapsed between t_1 and t_2 . And so a 60 year old person who made a bad choice in their youth can still, on the luck egalitarian account, be held responsible for that choice. We need not, then, provide redress for the disadvantage arising from their bad choices even all these years after the decision was made.

Some scholars argue that this is both counterintuitive and metaphysically implausible.³⁰ It seems appropriate that attributions of blame for one's choices should in some cases lessen over time, particularly where an individual has shown regret for their past decisions. If someone regrets or is sorry for how they have acted in the past, then we may be inclined to forgive them. There is also a deeper metaphysical question about whether an individual at time x is a completely different person to the person they were many years ago. It could be argued that there is only a weak psychological and physical connection between someone

²⁸ Kristin Voigt. "The harshness objection: is luck egalitarianism too harsh on the victims of option luck?". *Ethical Theory and Moral Practice* 10;4 (2006): 389-407; 391.

²⁹ Tomlin describes this view as "static luck egalitarianism". See Patrick Tomlin. "Choices, chance and change: luck egalitarianism over time". *Ethical Theory and Moral Practice* 16;2 (2013): 393-407; 396.

³⁰ Ibid.; Carl Knight. "Abandoning the abandonment objection: luck egalitarian arguments for public insurance". *Res Publica* 21;2 (2015): 119-135.

who is now old and their younger self. As such, it becomes problematic to blame someone for their past decisions, as they have only a weak psychological and physical connection to their past selves. In light of this, Tomlin writes: “What is fair the morning after [a choice] might not be fair after 50 years”.³¹ Tomlin argues that, when making decisions about whether to lessen inequalities, we should consider the person here and now rather than looking at their past self:

“Instead of asking whether or not, or to what extent, a person was responsible for the choice at the time of choosing, we should ask whether, or to what extent, they are responsible for the choice at the point at which we are seeking to discover whether, or to what extent, the inequality is unjust”.³²

In this sense, a strict luck egalitarian approach to *option-outcome inequality* seems insensitive to the lessening of ascriptions of blame over time.

Critics of luck egalitarianism suggest that we should introduce a concept of *diminished responsibility* indexed to the time elapsed between the time of an individual’s bad choices and the present moment. Specifically, Tomlin argues that we should give people lifelong opportunities, or multiple opportunities, rather than ‘one time’ opportunities that leave people having to deal with the effects of their (bad) choices for the rest of their lives. He writes:

“We should not think of the distinction between responsibility and luck as a static one, but rather a dynamic one...Over time, as we change, actions may slide from responsibility-generating to matters of luck, and inequalities directly traceable to that action [will] therefore [be] less and less acceptable from the standpoint of justice”.³³

This would seem to be more in line with our intuitions regarding the diminution of responsibility over time. It fits with the idea that people should not be punished indefinitely for their bad

³¹ Tomlin 2013, 406.

³² Ibid., 394.

³³ Ibid., 405. See also Knight 2015, 128-130.

decisions, but rather should be helped after a certain period of experiencing hardship as a result of their choices.³⁴ In the context of the allocation of scarce healthcare resources, it would mean taking seriously the fact that, though someone may have acted recklessly in the past and damaged their health, all people deserve an opportunity to access lifesaving healthcare resources provided they have a genuine need for these interventions. We should, then, refrain from penalising a person in need of lifesaving resource based on decisions they made many years ago that may have contributed to their illness.

In summary, the harshness criticism holds that luck egalitarian penalties for reckless or irresponsible behavior are unduly harsh, and that we should be wary of penalising people for their foolish actions – particularly where significant time has elapsed since one’s reckless behaviour and the present. It also intersects with deeper metaphysical worries about attributions of responsibility.

3.3: Responses

Luck egalitarians have responded to the responsibility criticism by arguing that attributions of responsibility in healthcare, while sometimes difficult, are by no means impossible.³⁵ They claim that, even despite the difficulties associated with attributing blame for addiction and harmful behaviour, such ascriptions of responsibility are at least in principle possible. While in many cases addictions are attributable to environmental and social factors, in other cases it is clear that a person has made a considered decision to engage in reckless behaviour, and they have deliberately not sought help to break their addiction. Albertsen, for example, identifies a number of moments when choice may play a role in addiction. These include when an

³⁴ Cf. Mark Navin. “Luck and oppression”. *Ethical Theory and Moral Practice* 14;5 (2011): 533-547.

³⁵ Knight 2015, 121-122.

individual first makes the decision to drink, or if they refrain from seeking help when addicted, or if they refrain from following the advice they are given by clinicians.³⁶ Individuals in this category may be held at least partially responsible if they develop ARESLD. Their responsibility is not lessened by the fact that once addicted it is exceedingly difficult for them to refrain from further alcohol consumption. What matters, Albertsen suggests, is whether they “could be considered responsible for initiating the abuse leading to [...] addiction or responsible for whether or not one seeks counselling”.³⁷

This response fails, however, to blunt the full force of the objection. First, the role that personal choice plays in addictive behaviour remains unclear. Albertsen, for example, states that personal choice can play some role in addictive behaviour, but he has provided us with only a cursory account of how personal choice can be distinguished from other environmental and genetic factors. It would seem that in practice it is particularly difficult to distinguish personal choice from social influences. Albertsen suggests that the initial decision to begin drinking may be where we situate the locus of personal responsibility; but this initial decision may itself be the product of a complex range of social and environmental factors.³⁸ For example, it would seem harsh to attribute responsibility for a first foray into alcoholism to a person who is from a disadvantaged background and who comes from a family with a history of alcoholism.

Second, it is even more difficult to see how such a position could be operationalised in public policy.³⁹ Some have suggested that we should use as our benchmark for responsibility how someone compares with their peers in their effort to avoid reckless behaviour and an

³⁶ Albertsen 2016, 229.

³⁷ Albertsen 2016, 330.

³⁸ Cf. Marmot 2004, 148.

³⁹ Nicholas Barry. “Defending luck egalitarianism”. *Journal of Applied Philosophy* 23;1 (2006): 89-107; 97-98. Barry notes that “it is unusual to have full knowledge of the risks involved in taking a particular option” (p.97).

unhealthy lifestyle. Thus, for example, when assessing how culpable a black steel worker is for their long-time heavy smoking, we should compare them to other black steel workers in similar circumstances.⁴⁰ Others have suggested that a committee of experts could determine if an individual is responsible for their own destructive behavior.⁴¹ But suffice to say such procedures for determining responsibility would be mired in controversy and are at risk of gross arbitrariness in their conclusions. It would be difficult to ensure, for example, that the general principles governing a citizens committee or expert panel are applied equitably between cases. There would also be problems related to the privacy of individuals should they be subject to intrusive responsibility assessments.

In response to the harshness objection, proponents of luck egalitarianism argue that trade-offs between individuals are inevitable under conditions of scarcity; they suggest that a tie-breaker principle such as personal responsibility is a logical criterion for discriminating between persons. It may be the case that treatment should be provided for self-inflicted conditions when such treatments come at little or no expense to society. Yet in the case where we must decide how to allocate organs, vaccines, ventilators or other invisible resources among persons, we should prioritise those who are not responsible for their conditions over those who are. Thus, Albertsen writes:

“When we cannot avoid denying treatment to some, is it really that implausible to tilt the scales slightly in favour of those who did not bring their need upon themselves? When the luck egalitarian claim is that responsibility should be considered alongside other factors, and when scarcity forces tough choices upon us, the policies that luck

⁴⁰ John Roemer. “A pragmatic theory of responsibility for the egalitarian planner”. *Philosophy and Public Affairs* 22 (1993): 146–66; 150-53.

⁴¹ Carl Knight. “The metaphysical case for luck egalitarianism”. *Social Theory and Practice* 32;2 (2006): 173-189. See also Carl Knight. *Luck Egalitarianism: Equality, Responsibility and Justice*. Edinburgh: Edinburgh University Press, 2009.

egalitarians recommend seem not overly harsh ... everyone's needs are taken into account, but they are so along with questions of responsibility".⁴²

Albertsen, for example, suggests the idea of deducting points from the Model for End Stage Liver Disease (MELD) score of heavy alcohol users.⁴³ The MELD scoring system is used to determine the severity of a person's liver disease and to prioritise them for transplant.

A lottery is, however, a viable alternative to a responsibility-adjusted MELD scoring system. Essentially, we are looking for tie-breaker criterion to use when the health of multiple patients has rapidly deteriorated and they are in desperate need of a transplant. A random allocation mechanism could be employed akin to a randomisation procedure in a clinical trial.⁴⁴ This process would be quick, and it would give equal consideration to each candidate. It would respect the inalienable entitlement that each candidate has to basic healthcare.⁴⁵ It would also allow us to avoid the difficult questions raised about how a responsibility sensitive criterion should be implemented, be it via the MELD scoring system or other means. There are viable alternatives, then, to the use of responsibility-sensitive tie-breaker criteria.

An interlocutor might object that this does not at all seem fair to the candidates vying for a resource. One could imagine a scenario where, because of the outcome of a lottery, a heavy smoker receives a lung transplant over a highly health-conscious and disciplined non-smoker. The smoker will go on to live (and possibly keep smoking) while the non-smoker will die soon. This may seem grossly unfair to some. But my claim is that, when it comes to basic healthcare, we should not discriminate between persons on the basis of past history or behaviour. We

⁴² Albertsen 2016, 334.

⁴³ Ibid., 330-332.

⁴⁴ Cf. Duff Waring. *Medical Benefit and the Human Lottery: An Egalitarian Approach to Patient Selection*. Dordrecht: Springer, 2004: 153-162.

⁴⁵ Cf. Efrat Ram-Tiktin. "The right to health care as a right to basic human functional capacities". *Ethical Theory and Moral Practice* 15;3 (2011): 337-351.

move into very dangerous territory when we begin to base access to healthcare on subjective judgements about how deserving a person is of our help. Granted, many may have the intuition that a lottery is a fair way of breaking the tie between candidates. Prudence and caution, however, should lead us to adopt alternative means such as a lottery to adjudicate between candidates.⁴⁶

Luck egalitarians may reply to the “diminishing blame” criticism by arguing that forgiveness, and giving everyone a “fresh start”, is simply not an option when we need to make tough choices in times of scarcity. While there may be arguments for overlooking considerations of personal responsibility where this does not cost us anything, in conditions of scarcity we need to make decisions between individuals, and we cannot give everyone a “fresh start”. Luck egalitarianism provides us with one plausible way of determining who should get a scarce resource. It gives less priority to those responsible for their own illness, for if anyone is to have a second chance at life it should be an individual who is *not* responsible for having squandered their first chance of life.⁴⁷

While I can see how this response may provide an answer to critics calling for indiscriminate compassion, I think this is a distinct objection to Tomlin’s worry about diminishing blame. Tomlin is not concerned so much with forgiveness as with the objective culpability of individuals at present for decisions they made in the past. Tomlin believes that there may be metaphysical reasons to suggest that ascriptions of blame should be lessened over time, in accord with the intuition that “we should not (necessarily) be held responsible for all of our

⁴⁶ In any case, it should be remembered that persons who cannot abide by a post-operative treatment plan would be ineligible for procedures such as a lung transplant. And so if the smoker is incapable of abstaining from tobacco consumption, then they would be ineligible for the operation. The scenario would be a moot point.

⁴⁷ Albertsen 2016, 334.

choices *forever*".⁴⁸ Luck egalitarians must either concede that responsibility diminishes with time, or accept that they do not have an adequate response to Tomlin's criticism (which is far deeper than a mere "fresh start" criticism).⁴⁹

Perhaps a luck egalitarian could answer Tomlin's worry by suggesting that responsibility for some choices diminishes, but not to the extent that we should give equal consideration to a patient with non-alcohol related liver failure and someone needing a liver transplant for ARESLD. Suppose we are dealing with a reformed alcoholic in need of a liver transplant, and someone who needs a transplant for reasons unrelated to lifestyle. As we are choosing between an individual who has no blame for their condition, and one who bears some (albeit diminished) blame for their condition, we should prioritise the blameless patient over the former alcoholic. The fact that the alcoholic is reformed does not entirely mitigate their responsibility for their ARESLD. We are still warranted in using personal responsibility as tiebreaker criterion.

The acceptability of this response will depend on how one understands the notion of diminishing responsibility. If one believes that blameworthiness disappears given a sufficient amount of time, then one may not accept the response. If one only thinks that blame diminishes over time but never fully disappears, then the response seems more plausible. Suffice to say that the response is not uncontroversial, and opponents of luck egalitarianism argue cogently for the use of alternative criteria in tie-breaker situations where responsibility might otherwise be invoked.

⁴⁸ Tomlin 2013, 394. See also Knight 2015, 129.

⁴⁹ Cf. Marc Fleurbaey. "Freedom with forgiveness". *Politics, Philosophy and Economics* 4;1 (2005): 29-67.

Even if one accepted this luck egalitarian rejoinder, however, it remains the case that persons are entitled to a basic level of healthcare independent of their responsibility for their illness. In the following section, I will briefly outline why respect requires that we give equal weight to the claims of persons regardless of the responsibility they bear for their illness.

4. Self-inflicted illness and claims of need

Having discussed various criticisms of the luck egalitarian framework for healthcare resource allocation, it is appropriate to consider how a responsibility criterion for allocation differs from the framework of respect for persons that I have been defending in this thesis. One primary difference is that, on a responsibility-based view of resource allocation, one can effectively forfeit (or, at least, greatly lessen) one's claim on lifesaving medical care. But proponents of a framework of respect for persons (at least, those who defend a framework akin to the one advanced in this thesis) argue that we should respond to claims of need regardless of a person's responsibility for their illness. In chapter two, I argued that we have a duty to take people's claims of need into consideration when deliberating about the allocation of resources. I argued that this duty arises from a more basic duty to show respect for the moral authority of persons. Respecting persons entails taking their claims seriously, and, where conflicts arise between claims, we should prioritise those patients with the strongest claims. Furthermore, we should respond to claims even when people have acted recklessly and done harm to themselves.⁵⁰ The moral authority of others is grounded in their standing as practical reasoners, and this moral authority is not diminished by behaviour or personal history.⁵¹ This is because the normative force built into their claims concerning an urgent health need here and now is not cancelled by a claim of responsibility; at the very least, the onus falls on the

⁵⁰ Denier 2005, 233.

⁵¹ Darwall 2006, 140-142; See also Jonathan Wolff. "Fairness, respect and the egalitarian ethos revisited". *The Journal of Ethics* 14;3-4 (2010): 335-350.

luck egalitarian to make that case, and as we saw in earlier sections this is not an easy case to make.

Persons should be respected even in cases where we are dealing with candidates with equivalent needs. The fact that candidates have equivalent needs has no impact on the strength of each candidate's claim on resources. The use of responsibility as a tie-breaker criterion, however, implies that a person's entitlement to healthcare is at least to some extent conditional on circumstantial factors rather than their moral status as persons. We should not, therefore, use responsibility as a criterion for rationing, even when we are dealing with persons with equivalent claims.

Surprisingly, there are luck egalitarian theorists who endorse the view that persons have an inalienable entitlement to healthcare. Segall, for example, maintains that it is a moral requirement for the state to seek to meet people's basic needs on account of their "intrinsic moral urgency".⁵² He argues that the duty to respond to claims of need is something that precedes luck egalitarian considerations, such that we should never (ordinarily) deny someone access to basic healthcare, even where we have reason to think they are responsible for their ill-health. Segall believes that responsibility should be taken into consideration, but only after appropriate treatment has been provided (perhaps in the form of a monetary penalty).⁵³ We should never abandon people, he argues, even where they are responsible for their own misfortune.⁵⁴

⁵² Segall 2010, 75-78.

⁵³ Ibid., 78. Specifically, Segall endorses the idea of charging patients more for treatment if they are responsible for their illness.

⁵⁴ Ibid., 58-59; 68-72.

In situations of scarcity, Segall has proposed a weighted lottery as a compromise between luck egalitarianism and basic needs principle.⁵⁵ On Segall's model, persons who are responsible for their illness would receive a chance of winning the lottery, albeit a diminished chance in comparison to other persons who are not culpable for their illness. Segall argues that this is a way to avoid the harshness objection while preserving our intuitions that responsibility should play some role in our allocation decisions.

Still, there is a question about whether blame should play *any* role in our distribution of life-saving resources. Some theorists argue, plausibly, that basic healthcare is the sort of thing we should not be distributing on the basis of problematic ascriptions of blame. Rather, we should recognise the entitlement to healthcare that all persons have by virtue of being persons.

As Nielsen writes:

“People are entitled to basic health and health care due to the mere fact that they are persons—that is, being a person entails the right to be able to live a life of normal human functioning—and thus these entitlements are inalienable”.⁵⁶

If we accept that people have an inalienable entitlement to basic healthcare, then even a weighted lottery seems problematic. For the subtext of a weighted lottery is that a person's entitlement to basic healthcare is alienable, or, at least, can be lessened based on a person's reckless behaviour.⁵⁷

More generally, it is unclear what is left of luck egalitarianism as a theory of distribution if one adopts Segall's approach. Resource scarcity is ubiquitous in healthcare rationing, as well as

⁵⁵ Segall 2010, 71-72.

⁵⁶ Nielsen 2013, 414.

⁵⁷ I would argue that the claims “in force” in the community are such as to generate an inalienable entitlement to healthcare. This entitlement is, of course, qualified by the strength of the claims that others have on healthcare. Yet every person still has a *pro tanto* entitlement to healthcare.

other domains of distributive justice. It seems that luck egalitarians like Segall would constantly be relying primarily on alternative moral considerations to make distributive decisions, rather than allowing luck, responsibility and desert to function as decisive criteria in resource allocation. Thus, Nielsen and Axelsen write:

“...resource scarcity is the standard case in health and health care distribution, and therefore [...] luck egalitarian justice is constantly compromised. If luck egalitarian justice is something that we are to take seriously it seems peculiar that it is to be compromised by other moral requirements whenever the presence of resource scarcity sets justice to conflict with these – particularly since such shortages are almost always the case in actual health policy”.⁵⁸

If this is correct, Segall’s luck egalitarianism collapses into a pluralist theory of justice in which luck is just one consideration among others. He could of course abandon his commitment to meeting basic needs, yet this would give rise to harshness worries of the sort addressed in the previous section. It is not clear then, what remains of Segall’s luck egalitarianism as a distinct theory of distributive justice.

Conclusion

In this chapter I have offered an overview of luck egalitarian, responsibility-sensitive criteria for healthcare resource allocation. I have considered some powerful objections to the application of a responsibility-sensitive criterion to healthcare rationing, and have suggested that luck egalitarians fail to provide an adequate response to these criticisms. It is exceedingly difficult to make attributions of responsibility for illness, and a responsibility-sensitive criterion could be subject to abuse and misapplication. Furthermore, we should still give due consideration to the claims that persons make on our assistance even in cases where a person

⁵⁸ Nielsen, Axelsen 2012, 304.

is clearly responsible for their own health condition. That is to say, using responsibility as the defining criterion for allocation, in my view, conflicts with the ethos of a framework based on respect for persons. Rather than employing a responsibility principle, I argue that rationing decisions are best made on the basis of prioritising those individuals who are worst off. And in situations where we are dealing with persons with equivalent needs, tie-breaker principles such as lottery, waiting list, or first come, first served policy should take precedence over a responsibility-sensitive criterion for allocation.

Recently, several scholars have argued for a desert-based account of distributive justice, as opposed to a theory of justice focused on equality and luck.⁵⁹ These theorists argue that luck egalitarianism fails to explain our intuitions about how people should be rewarded and blamed in different situations.⁶⁰ It is beyond the scope of this thesis to make a judgement about the plausibility of so-called desertist theories of justice. Suffice to say that the criticisms presented here of luck-egalitarian approaches to rationing would also pertain to desertist approaches to healthcare rationing. The criticisms apply to all theories that invoke responsibility as a criterion for rationing.

In the next two chapters, I will consider how a framework of respect for persons applies in two real world scenarios. These are, namely, the allocation of vital organs under conditions of scarcity, and the allocation of vaccines and treatment in a pandemic scenario. I will consider how this framework differs from current allocation protocols, as well as revisionary resource allocation protocols that have been proposed in the literature. I will argue that the framework of respect for persons is both theoretically defensible *and* feasible as a real-world protocol for rationing.

⁵⁹ See, for example, Thomas Mulligan. *Justice and the Meritocratic State*. New York: Routledge, 2018.

⁶⁰ Huub Broer, Thomas Mulligan. "Why not be a desertist? Three arguments for desert and against luck egalitarianism". *Philosophical Studies* (2018): doi.org/10.1007/s11098-018-1125-4.

Chapter 7: Health Need and the Allocation of Vital Organs in Conditions of Scarcity

This thesis has offered an extensive overview of some of the key ethical debates surrounding healthcare resource allocation. Our focus now turns to practical ethical scenarios in which the State must make decisions between persons in need. Specifically, this chapter will consider how we should ration lifesaving organ transplants, while the following chapter will discuss the allocation of vaccine and treatment in a pandemic scenario. These two case studies provide concrete insight into how the State might resolve moral dilemmas that arise in the allocation of lifesaving healthcare resources.

Recent literature on organ allocation has assayed the egalitarian ethos of existing allocation protocols. Several theorists have argued for a revision of the current criteria with which we ration organs. These theorists argue that existing egalitarian approaches to the rationing of organs lead to radically inefficient or inequitable outcomes.¹ Rather than rationing on the basis of need, it is argued that we should allocate organs on the basis of utility,² age,³ or personal responsibility for illness.⁴ The ethical basis of each of these criteria has been discussed in the preceding chapters.

¹ Peter Reese. "How should we use age to ration health care? Lessons from the case of kidney transplantation". *Journal of the American Geriatrics Society* 58;10 (2010): 1980-1986. Cf. Howard Brody. "From an ethics of rationing to an ethics of waste avoidance". *The New England Journal of Medicine* 366 (2012): 1949-1951.

² Stein 2012, 47-56.

³ Persad, Wertheimer, Emanuel 2009, 423-431; Tallman 2014, 207-213; Kamm 1998, 268-283.

⁴ Albertsen 2016, 325-338.

This chapter will, however, argue that our framework for rationing organs should be based on an ethic of respect for persons. Specifically, we respect persons by prioritising those persons with the strongest claims of need. Our allocation of organs, then, should be based on the strength of the claim of need that each person makes on these resources. Section one and section two of this chapter offer an overview of the context in which organ rationing occurs. Section three evaluates extant organ allocation protocols from the perspective of a framework of health need. The notion of a minimum capacity to benefit is discussed, and a criterion of medical urgency is defended. Section four of this chapter discusses alternative proposals for the rationing of organs, including lifetime egalitarian and responsibility-sensitive criteria for the rationing of vital organs. It critically evaluates these criteria from the perspective of a framework of respect for persons.

Policy makers face the challenge of developing protocols that are in accord with ethical standards but that also are medically feasible and that meet public expectations for how donated organs should be allocated. This chapter is not intended to rule out policy debate about how we can reconcile what sometimes appear to be irreconcilable aims of organ transplantation registries. Rather, it aims is to provide clarity on the ethical principles underlying our organ allocation policies, and to consider to what extent these principles are in accord with a needs-based framework for allocation.

1. Scarcity and organ transplantation

Organ shortages are a chronic problem affecting most healthcare systems around the world. In the United States, for example, there were over 116,000 people on the organ donation waiting list as of August 2017. The number of transplants performed in 2016 was just 33,611. Approximately 20 people are believed to die each day waiting on the US organ transplantation

register.⁵ While Australia has a higher organ donation and transplantation rate than the US, the effects of an organ shortage are still felt. In 2014, 1151 solid organ transplants were performed in Australia, while 49 patients died on the waiting list.⁶

These statistics raise the question of how we should understand the concept of scarcity in organ allocation. Viewed from one perspective, it might appear that the scarcity of organ transplants is something *temporary*. That is, if we are unable to provide a transplant for a patient now, we will likely be able to do so in the future. This appears to be the assumption built into many extant organ allocation policies, which give absolute priority to patients who are facing imminent death. The thought is that transplants will be available in the future for those patients who are *not* facing imminent death.

It is by no means certain, however, that someone who misses out on a transplant now will receive one in the future. It may be the case, for example, that the organ that we are allocating now is from a donor with a rare blood type or rare tissue antigen subtype. As such, it may be the case that the patients who are matched with this organ but do not receive the transplant may never get another chance in the future to receive a suitably matched transplant. More generally, the prognosis of patients on the organ transplantation registry is unpredictable, and as such even patients whose need for a transplant is “non-urgent” may experience a rapid deterioration in health should they not receive a transplant soon. Persad *et al* go as far as to claim that “preferential allocation of a scarce liver to an acutely ill person...ignores a currently

⁵ US Department of Health and Human Services. “Organ Donation Statistics”. Washington DC: HHS, 2017. Available from <https://www.organdonor.gov/statistics-stories/statistics.html>.

⁶ Organ and Tissue Authority. *Australian Donation and Transplantation Activity Report 2015*. Canberra: Organ Tissue Authority, 2016.

healthier person with progressive liver disease, who might be worse off when he or she later suffers liver failure”.⁷

As stated in the earlier chapters of this thesis, we can draw a distinction between three different kinds of scarcity: *true scarcity*, *temporary scarcity*, and *a condition of uncertainty*. True or absolute scarcity refers to a situation where “if we give an organ to one person rather than another, the person who does not get it will never get another of the same type”.⁸ That is, the person who does not receive a transplant now will experience the full effects of organ failure and perhaps death. True scarcity can be contrasted with temporary scarcity. In temporary scarcity, if we give an organ to one person rather than another, the person who does not get it will experience the bad effects of their illness for a time, but will receive a transplant in the future. That is, they will not die, even though they will have to wait for an organ. The third kind of scarcity is *a condition of uncertainty*, in which we do not know if an organ will become available in the future. There may be uncertainty about future organ donation rates, for example.

Kamm has suggested that, in Western organ allocation systems, “we are most often in a condition of uncertainty”.⁹ This would seem to be a fair description of the risks and unpredictability typically involved in allocating organs. There is invariably some degree of uncertainty about whether suitable organs will be available in the future (we might call this ‘supply side uncertainty’). There is significant unpredictability surrounding how many organs will be donated in future years. Overall organ donation rates in the United States, for example,

⁷ Persad, Wertheimer, Emanuel 2009, 425.

⁸ Kamm 1998, 233.

⁹ Ibid., 234.

have fluctuated considerably in the past two decades.¹⁰ There is also uncertainty about whether an individual will survive long enough to receive a transplant in future (we might call this ‘demand side uncertainty’). It is perhaps reasonable to expect that some persons with very common blood and tissue types, and who can live several years without a transplant, will live long enough for other organs to become available. Yet there will be persons with a worse prognosis and rare blood and tissue types who need a transplant immediately. The future of these persons will be very uncertain should they not receive a transplant.

For the rest of this chapter I will focus on allocation situations involving uncertainty. I will consider how we should act in situations where if someone does not receive a transplant now there is a possibility that they will die – or, at least, have to bear the burden of illness for a significant period of time – before having another opportunity to receive a graft. This includes any organ allocation situation where we do not have certainty that another transplant will become available for candidates in the future. I will, however, attempt to distinguish between different levels of uncertainty that might be encountered in the context of resource allocation.¹¹

2. Current procedures for allocation

Different countries have different procedures for matching organs with recipients. We can, nevertheless, identify certain commonalities in the different systems for organ allocation. The

¹⁰ US Government Information on Organ Donation and Transplantation. “Organ Donation and Transplantation Statistics: Graph Data”. Washington DC: US Department of Health and Human Services, 2019. Available from <https://www.organdonor.gov/statistics-stories/statistics/data.html>.

¹¹ Waring (2004, 9-10) argues that all organ allocation decisions have a *tragic choice* dimension to them: “We know that many candidates die each year from end-stage organ failure if they do not receive the organs they need but we are frequently uncertain as to whether this particular candidate will be one of them...the fact that we cannot always predict the death from organ failure of any one of the candidates who did not receive the most recently available organ does not ...negate the tragic context of the transplant decision.” Yet I would argue that the gravity of our decisions varies depending on how scarce organs are at a particular time.

United States, Australia and the United Kingdom, for example, have a central registry for allocating organs to patients on a waiting list. Patients must meet certain eligibility criteria if they are to be added to the registry. Once on the registry, computer algorithms are used to match donor organs with patients.

While criteria for allocation differ depending on the type of organ being allocated, there are, nevertheless, certain common criteria that typically are considered. The following box outlines the main factors that are taken into consideration both when admitting someone to the organ registry and when selecting patients on the registry for a transplant.¹²

BOX 1: SELECTION CRITERIA FOR THE ALLOCATION OF VITAL ORGANS

CRITERION	EXPLANATION
Medical urgency	The urgency with which a patient needs a transplant to survive.
Medical factors which affect the likelihood of success	These include comorbidities, tissue matching, size of the organ needed, and other factors.
Relative severity of illness and disability	The impact of a person’s illness or disability on their quality of life.
Age of the recipient	Some organ transplantation registries take into account the age of the recipients receiving a

¹² Organ Procurement and Transplantation Network. “How organ donation works”. Washington DC: US Department of Health and Human Services, 2019; The Transplantation Society of Australia and New Zealand. *Clinical Guidelines for Organ Transplantation from Deceased Donors*. Sydney: TSANZ, 2017; NHS Blood and Transplant. “Introduction to selection and allocation policies”. Watford: NHS Blood and Transplant, 2018.

	transplant, and match organs from younger donors with younger recipients.
Length of time on waiting list/dialysis	The amount of time a person has spent on the registry waiting for a transplant. In the case of kidney transplants, doctors take into account the time that a patient has spent on dialysis.
Capacity to comply with a post-transplantation treatment plan	Clinicians consider if patients are likely to observe the necessary post-operative treatment regimen. Those who have problems with substance abuse may be incapable of abstaining from the consumption of narcotics or alcohol post operation.
Geographical factors	In cases where it is not possible to transplant an organ long distances, it may be necessary to allocate the organ to a transplant centre that is close by. ¹³

Importantly, the algorithm for organ allocation differs depending on the organ that is being allocated. In Australia, the algorithm for kidney transplantation takes into account

¹³Chad Southward, Matthew Prentice. *Geographic Organ Distribution Principles and Models Recommendations Report*. Washington DC: OPTN, 2018. Available from: www.optn.transplant.hrsa.gov/media/2506/geography_recommendations_report_201806.pdf.

blood group compatibility, immunological factors, as well as waiting time on dialysis.¹⁴ The criteria for heart transplantation is slightly different. Criteria include size and weight matching, blood group compatibility, urgency, time on the waiting list, and logistical considerations.¹⁵

Depending on the circumstances, some of these criteria will take priority over others. For example, guidelines may allow for medical urgency to take priority over time spent on the waiting list when we are dealing with a patient facing death in a matter of days or weeks. Geographical factors may also mean that a patient who would otherwise be an appropriate recipient for an organ does not receive it. For example, most kidneys in Australia are allocated within the state in which they were donated as there is no great advantage to be gained by transporting the kidneys interstate.¹⁶ Within states, the majority of kidneys are allocated based on waiting time.¹⁷

There are, however, a series of new developments in organ transplantation that have impacted on the criteria according to which organs are allocated. One development is the practice of matching organs from younger donors with younger recipients. For example, a system was introduced in the US in 2014 whereby candidates with longest Estimated Post Transplant Survival (EPTS) receive kidneys with the highest Kidney Donor Profile Index (KDPI) score (indicating longest potential function).¹⁸ Transplant surgeons in other countries are campaigning for the introduction of a similar system.¹⁹ There is also growing acceptance of

¹⁴ Chapman and Kanellis 2018, 243.

¹⁵ TSANZ 2017, 35-36.

¹⁶ TSANZ 2017, 46.

¹⁷ Ibid.

¹⁸ Diana Wu. "Global trends and challenges in deceased donor kidney allocation". *Kidney International* 91;6 (2017): 1287-1299.

¹⁹ See, for example, Chapman and Kanellis 2018, 242-243.

the practice of procuring organs from patients with serious diseases such as HIV and hepatitis.²⁰ When procured these organs can be allocated to candidates who already have these diseases.

There are, nevertheless, a range of substantive ethical questions about how the criteria for organ allocation should be ranked. We must consider, for example, how much significance we give to a patient's capacity to benefit, and whether medical urgency should take precedence over a waiting list criterion. It is to these questions that we now turn.

3. An evaluation of extant allocation protocols from the perspective of a framework of need

This section evaluates existing organ allocation protocols from the perspective of a framework of respect for persons and a criterion of need. To be clear, this section is not intended to provide an exhaustive account of how in practice we should choose to allocate organs. This would require a close consideration of the medical complexities of transplantation, as well as a consideration of the public's attitudes towards organ allocation protocols. Such a discussion is beyond the scope of this thesis.

The basic assumption of a framework of respect for persons, as outlined in chapter two, is that we should prioritise those persons with the strongest claim on a lifesaving resource. In practice, this would involve identifying which patients had the most advanced illness, and which patients faced imminent death should they not receive a transplant. The patients who would receive first priority, then, would be those facing an immediate threat to life (should there

²⁰ Scott Halpern, Peter Ubel, Arthur Caplan. "Solid organ transplantation in HIV-infected patients". *The New England Journal of Medicine* 347;4 (2002): 284-287.

be candidates who are in such a position).²¹ Such persons would need to meet a threshold of capacity to benefit to be eligible for a transplant. But provided we are dealing with patients who have met the stipulated threshold of capacity to benefit, we should prioritise the patients with the most severe and urgent needs.²²

Current allocation protocols, however, are based on multiple ethical principles.²³ Health need features in existing protocols, for patients must have end stage organ failure, and have exhausted other treatment options if they are to be eligible for a transplant. That is, only patients who are reliant on a transplant as a last resort are typically admitted to the registry.²⁴ But in addition to medical need, organ transplantation protocols are also based on the principles of equity and utility.²⁵ Most allocation protocols take into consideration how long an individual has spent on the organ transplantation registry. Such a consideration is aimed at ensuring fairness or equity in the way we select candidates for transplant from among persons on the registry. Protocols also take into account utility insofar as they outline benefit thresholds that a patient must meet if they are to be considered eligible for a transplant.

It is appropriate for us to consider how these different criteria for allocation can be reconciled with a framework of respect for persons. This thesis has argued that we should respond appropriately to the claims that other moral agents make on the resources in our control. At a

²¹ Richard Cookson, Paul Dolan. "Principles of justice in health care rationing". *Journal of Medical Ethics* 26 (2000): 323-329.

²² Cf. Philip Rosoff. *Drawing the Line: Healthcare Rationing and the Cutoff Problem*. London: Oxford University Press, 2017: Ch.7.

²³ Cf. Peter Ellis. "Resource allocation: exploring concepts of justice and utility". *Journal of Kidney Care* 3;1 (2018); Georg Spielthener. "The principle-based method of practical ethics". *Health Care Analysis* 27;3 (2017): 275-289.

²⁴ TSANZ 2017, vi. One exception is kidney transplant candidates who are still granted admission to the registry despite the fact that they may technically be able survive on dialysis.

²⁵ Aisling Courtney, Alexander Maxwell. "The challenge of doing what is right in renal transplantation: balancing equity and utility". *Nephron Clinical Practice* 111 (2009): 62-68.

macro-level, we should consider the claims that are “in force” in our moral community. A criterion of need should be used to resolve conflicts between competing claims. We should consider, then, whether a reliance on the principles of equity and utility in organ allocation can be reconciled with respect for persons and the use of a criterion of need.

3.1: Medical need and capacity to benefit

Many organ allocation networks require that patients have a minimum capacity to benefit from treatment. Specifically, patients must have a high probability of surviving for several years post-transplantation if they are to be eligible for a transplant. The Transplant Society of Australia and New Zealand (TSANZ), for example, has published specific guidelines on what the minimum expected survival rate for patients post-transplant should be. In regard to liver transplants, the Society states that:

“Patients who are estimated to have less than a 50% likelihood of surviving at least five years after liver transplantation, and patients who are predicted to have an unacceptably poor quality of life post-transplant, are considered ineligible for wait-listing”.²⁶

Similar requirements must be met for patients to be listed for other kinds of transplants. In fact, the threshold is higher for organs such as hearts. Patients in Australia in need of a heart transplant must have a postoperative life expectancy of at least 10 years if they are to be considered eligible for a transplant.²⁷

The question we must consider is whether (and under what circumstances) a benefit threshold is compatible with respect for persons. To answer this, we should determine whether benefit

²⁶ TSANZ 2017, 55.

²⁷ *Ibid.*, 28.

thresholds lead to patients being denied care despite the fact that they are in need of it. In a previous chapter, it was suggested that the concept of need implies that a patient is capable of obtaining a *significant and meaningful benefit* from treatment.²⁸ We must therefore consider what would count as a significant and meaningful benefit from organ transplantation. We should, furthermore, outline the appropriate means by which health authorities can establish benefit thresholds for treatment.

There are a range of medical indications that one could use to define the idea of significant and meaningful benefit in the context of organ transplantation. One option would be to rely on a concept of medical futility. By medical futility, I have in mind treatments that would be clinically ineffective for a particular patient.²⁹ A treatment is medically futile when it does not bring about any medical benefits for a patient, or causes harm that outweighs the benefits obtained. For example, an organ transplant would be considered futile for someone who had no reasonable prospect of surviving in ICU post-operation. A patient would experience massive medical burdens post treatment and would die within weeks. This use of organs would constitute “a deliberately futile, wasteful use of resources”.³⁰

Yet futility is too low a threshold to establish a need for treatment.³¹ While a patient may survive the immediate period post-operation, it may be the case that they have very poor quality of life, or only survive for one or two months before their transplant starts to fail. A treatment is

²⁸ Rosoff uses the expression “clinically meaningful, beneficial care”. See Phillip Rosoff. *Drawing the Line: Healthcare Rationing and the Cut Off Problem*. London: Oxford University Press, 2016: 94.

²⁹ Cf. Lawrence Schneiderman. “Defining medical futility and improving medical care”. *Journal of Bioethical Inquiry* 8 (2011): 123; Lawrence Schneiderman, Nancy Jecker, Albert Jonsen. “Medical futility: its meaning and ethical implications”. *Annals of Internal Medicine* 112;12 (1990): 949-954.

³⁰ Waring 2004, 141.

³¹ *Ibid.*, 136-143.

not clinically indicated in situations where a patient has such a dire post-operative prognosis.³² To be clear, I am not conflating clinical indications with a moral conception of need.³³ I do, however, contend that clinical insight can inform our moral evaluation of the extent to which a patient has a claim on treatment. A transplant operation may be very burdensome for a patient, and also involves a burdensome post-operative treatment plan. This fact must be balanced against any considerations of the benefits to be obtained from a transplant.

Plausibly, there is scope for reasonable disagreement about what constitutes a significant and meaningful benefit in the context of transplantation. As Waring observes, “moving away from physiological futility can involve contentious value differences about whether responses to treatment that some might consider worth having amount to benefits worth providing”.³⁴ Different clinicians, for example, might have different views about what is a sufficient life extension for patients to be eligible for a heart transplant. Some may believe that three years of extra life is a good enough benefit from a transplant, whereas others may believe that patients should be expected to live for at least five years post-operation.

In light of this, thresholds would be best established through processes of stakeholder deliberation rather than being stipulated by one decision-maker. By stakeholder deliberation, I have in mind a process in which relevant stakeholders share opinions and seek consensus on topics of reasonable disagreement. The aim of these processes is to identify points of agreement among stakeholders, and to arrive at a conclusion that encapsulates different

³² Cf. Kirsten Howard *et al.* “Community preferences for the allocation of donor organs for transplantation: a discrete choice study”. *Transplantation* 99;3 (2015): 560-567; Carina Oedingen *et al.* “Systematic review of public preference for the allocation of donor organs for transplantation: principles of distributive justice”. *The Patient: Patient Centred Outcomes Research* (2019): 1-15.

³³ Horne 2016, 588-596.

³⁴ Waring 2004, 141.

reasonable viewpoints.³⁵ This process would accommodate for the fact that reasonable persons can disagree about questions of clinical benefit and fairness in allocation. A process of reasoned deliberation would, plausibly, lead us to a reasoned and balanced conclusion about what constitutes a minimum threshold of benefit for different transplants. It could utilize hard scientific evidence for and against transplantation as well as “clinical judgment, a much softer and subjective view which [would be] undoubtedly influenced by the panel [participants’] clinical experience”.³⁶

The fact that there is a subjective dimension to the concept of benefit gives health authorities a reason to consult patients and the general public when deliberating about minimum benefit thresholds for transplantation. The process of deliberation should engage *all* stakeholders in organ transplantation, rather than focusing on clinicians alone.³⁷ Granted, there is a certain wisdom contained in the perspectives of those who are somehow invested in the organ allocation system. Doctors have the clinical expertise to judge how much a patient stands to gain from treatment. They, furthermore, have a first-hand awareness of the scarcity of organ transplants. The perspective of members of the public and patients is also relevant, however, for the public are the source of organ donations, and patients must bear the effects of our decisions about benefit thresholds. In consulting various stakeholders we will tend towards an convergent understanding of what is a sufficient capacity to benefit. Our view will not be

³⁵ The term democratic deliberation is often used to refer to the work of Amy Gutmann and Dennis Thompson (see, for example, Amy Gutmann, Dennis Thompson. *Why Deliberative Democracy?* Cambridge: Harvard University Press, 2004). Yet I have in mind a more general sense of democratic deliberation that involves stakeholders seeking points of agreement amidst their disparate value commitments.

³⁶ Rosoff 2016, 83. Rosoff’s own rationing framework is reliant on “appropriateness committees” – committees staffed by both clinicians and laypersons – to make decisions about who should be eligible for treatment.

³⁷ Cf. Allison Tong *et al.* “Community preferences for the allocation of solid organs for transplantation: a systematic review”. *Transplantation* 89;7 (2010): 796-805.

confined to the purely medical conception of benefit that clinicians have; nor will it be limited to a lay perspective uninformed by the clinical realities of organ transplantation.

A defensible threshold of benefit will be one that captures the idea of a *significant and meaningful benefit* for a patient, while at the same time not lapsing into a crude utilitarian evaluation of treatment. Stakeholders should consider this in their deliberations. Furthermore, the benefit threshold may differ depending on the type of organ being allocated. There is a need to consider both the objective gains that come from treatment, including life extension and improved quality of life, as well as the subjective meaning of these benefits for patients. These benefits must in turn be balanced against the objective burdens of undergoing a transplant operation.

While there is some degree of ambiguity about what constitutes a meaningful and significant benefit from a transplant, we can nevertheless critically evaluate the utilitarian judgements that would appear to underpin some of the thresholds outlined in current organ allocation policies. Indeed, some of the current TSANZ life expectancy cutoffs for transplantation fail to recognise the normative ambiguity surrounding minimum benefit thresholds. Current TSANZ guidelines state that candidates for a heart transplant must have “an expected survival of at least ten years post-transplantation, with a reasonable prospect of returning to an active lifestyle”.³⁸ Yet this is a cut off based on what clinicians deem to be a non-wasteful use of a resource.³⁹ Ten years of extra life is deemed to be a sufficient utility for someone to merit receiving a heart transplant.

³⁸ TSANZ 2017, 28.

³⁹ Jame Neuberger. “Rationing life- saving resources – how should allocation policies be assessed in solid organ transplantation”. *Transplant International* 25;1 (2012): 3-6.

Patients who live for shorter periods than this, however, may still profit in a meaningful way from treatment. The TSANZ threshold for heart transplants, then, perhaps should be lower than ten years life expectancy. The threshold should be based on the minimum level of benefit necessary for a transplantation operation to be worthwhile, rather than a utilitarian judgement about organ wastage. Members of the public and patients should be consulted about what they take to be a sufficient capacity to benefit from a transplant (indeed, several surveys have already been conducted on public attitudes towards organ allocation).⁴⁰

One could argue that existing thresholds are no more problematic than the threshold that would result from the process of deliberation that I have proposed. Existing thresholds, after all, have also come from a process of deliberation among clinicians. But there are two key differences between the existing deliberative procedures and the recommendation that I have made. First, my process of deliberation involves consulting not only clinicians but also patients and the general public. It is more democratic in character, and is predicated on the intersubjective agreement of all reasonable persons, not just members of particular profession. Second, I have argued that eligibility thresholds should be based on what is a significant and meaningful benefit from treatment. The thought is that we should have an egalitarian policy for transplantation, while not allocating resources to persons for who treatment is futile. TSANZ guidelines, in contrast, seek to balance equity with utility.⁴¹ For reasons presented in chapter four, however, we should be wary of integrating utilitarian considerations into our resource allocation decisions.

The basic policy recommendation arising from a framework of respect for persons, then, is that eligibility thresholds should function as a means of establishing that a patient has a need

⁴⁰ For a summary of several of community surveys, see Alison Tong *et al.* "Community preferences for the allocation of solid organs for transplantation: a systematic review". *Transplantation* 89;7 (2010): 796-805.

⁴¹ TSANZ 2017, 2.

for a treatment. Such thresholds should *not* be based on quasi-utilitarian judgements about what constitutes an acceptable use of a transplant. Rather, they should function as a means of establishing patient need.

3.2: Waiting lists and medical urgency

The concept of health need, as I have described it, concerns both the severity of a person's illness as well as the urgency with which that person requires treatment. A person who faces loss of life if they do not receive treatment has a stronger claim on a transplant than someone who may have the same symptomatology but is not likely to face a sudden deterioration of health. We should, then, prioritise those patients who are in urgent need of treatment – provided that the scarcity of organs is not absolute. In this section, I will offer a qualified defence of the use of an urgency criterion for organ allocation.

In almost all organ allocation systems, patients who are deemed eligible for a transplant are placed on a waiting list. The role that time on a waiting plays in determining if a patient will receive access to a transplant varies between jurisdictions. In Australia, for example, kidney transplants

“...are offered to waitlisted candidates according to the national and state allocation protocols ... which take into account recipient sensitisation, donor-recipient HLA-match and waiting time.”⁴²

Organ allocation waiting lists are not only based on time that has elapsed since candidates were admitted to the registry.⁴³ Rather, in the case of kidney transplants, waiting time will

⁴² TSANZ 2017, 42.

⁴³ TSANZ 2017, 42.

sometimes be calculated based on time spent on long-term dialysis.⁴⁴ One reason for this is that there may be delays in active listing due to medical factors or time taken to complete the necessary medical investigations. Time spent on dialysis provides a better indication of the burden of disease.

There are, however, exceptional circumstances where a patient may be allowed to bypass the waiting list. One such situation is where a patient is facing some immediate threat to life. With regard to heart transplantation, for example, TSANZ guidelines state:

“Under some circumstances—for example when transplant candidates are unsuitable for mechanical support or develop life-threatening complications while on support, and the patient’s survival is estimated to be days or weeks if they do not receive a transplant — the patient may be placed on an urgent list... It is expected that the majority of individuals placed on the urgent waiting list will either die or be transplanted within two weeks of notification”.⁴⁵

Patients on the waiting list in this situation receive absolute priority for transplant – i.e., they will receive a transplant as soon as an organ becomes available from a compatible donor.

Theorists have, however, raised concerns about the use of an urgency criterion.⁴⁶ An urgency criterion would appear to ignore the fact that other, healthier transplant candidates will face a deterioration of health in the future. As Persad *et al.* observe, “preferential allocation of a scarce liver to an acutely ill person unjustly ignores a currently healthier person with progressive liver disease, who might be worse off when he or she later suffers liver failure”.⁴⁷

⁴⁴ Ibid.

⁴⁵ Ibid., 32.

⁴⁶ Inge Varekamp *et al.* “The meaning of urgency in the allocation of scarce health care resources; a comparison between renal transplantation and psychogeriatric nursing home care”. *Health Policy* 44;2 (1998): 135-148.

⁴⁷ Persad, Wertheimer, Emanuel 2009, 425.

In light of this, some would argue that we should not take chances with the lives of other patients on the registry.

This criticism presumes that we are operating under conditions of absolute scarcity, *viz.*, a situation in which no suitable organs will be available in the future, or some situation in which there is limited likelihood of appropriate organs becoming available in the future. Indeed, where it is certain that more organs will not become available in the future, we should consider factors other than urgency. For despite the fact that some patients are less ill than others, there will inevitably come a time in the future where the healthier patients are just as ill as those who are very sick at present. There is a sense in which all eligible patients, regardless of their health, have an equal need of a transplant when there is only one available now and none will be available in the future. As such, we should not necessarily give priority to patients with a shorter life expectancy.⁴⁸

Organ allocation typically occurs, however, in a situation of temporary scarcity or conditions of uncertainty, and in these circumstances we should prioritise patients in urgent need. In temporary scarcity, the patient who does not receive a transplant now will experience the bad effects of their illness for a time, but will receive a transplant in the future.⁴⁹ The patient facing death, in contrast, may not get another opportunity if they do not receive a transplant now. Plausibly, we should give the dying patient priority, at least insofar as we take claims of need to be of primary moral importance. The patient who is dying has a more urgent need of the transplant than the patient who is able to survive for the short-term without a transplant.

⁴⁸ It may, however, be morally relevant that, in the case of transplantation, one patient has five years to live before they need a transplant while another patient will die within months if they do not receive a graft. The patient facing imminent death stands to lose more years of life, *ceteris paribus*, should they not receive the resource.

⁴⁹ Kamm 1998, 233.

It is important to consider what kind of uncertainty underlies the context in which we are allocating organs.⁵⁰ *Uncertainty* can mean different things in different contexts.⁵¹ It may mean that there is a good probability of new organs becoming available in the future, though we cannot be certain. Or it may mean that there is a “very slim chance” of organs becoming available in the future. Plausibly, we should treat situations where it is “very unlikely” that another suitable organ will become available for a patient as a situation akin to true scarcity. Yet we should treat the patient with the most urgent needs if there is a good possibility that more transplants will become available in the future. One must balance the likelihood of another organ becoming available in the future against the moral importance of attending to the patient most in need.

I do not mean to side-step meta-ethical questions about the normative significance we should give to uncertainty when it manifests in our ethical lives. Indeed, there is increasing recognition in practical ethics of the need for a principled normative account of how the fact of uncertainty should inform our ethical decision making.⁵² To some extent, ethicists are yet to develop a concrete framework to dealing with problems of uncertainty in medical ethics. And, as Hasson observes, the lack of theoretical attention given to the idea of uncertainty sometimes leads us to simply revert to conventional ways of managing uncertainty.⁵³ But we should instead be attempting to develop a concrete ethical framework for understanding the moral implications of uncertainty for decision-making.

⁵⁰ Cf. Thomas Rowe, Alex Voorhoeve. “Egalitarianism and severe uncertainty”. *Philosophy & Public Affairs* 46;3 (2018): 239-268.

⁵¹ See, for example, Phillip Rosoff. “Unpredictable drug shortages: an ethical framework for short term rationing in hospitals”. *The American Journal of Bioethics* 12;1 (2012): 1-9.

⁵² Tomasz Zuradzki. “Ethics and uncertainty: the guest editor’s introduction”. *Diametros* 53;1-5 (2017): 1-5; Stale Fredriksen. “Luck, risk, and blame”. *Journal of Medicine and Philosophy* 30;5 (2005): 535-553.

⁵³ Sven Ove Hasson. “Uncertainty and the ethics of clinical trials”. *Theoretical Medicine and Bioethics* 27;2 (2006): 149-167.

To develop such a framework would, however, take us beyond the scope of this thesis. Suffice to say that we are warranted in prioritising patients based on their claims of need in cases where we can be confident about the future availability of kidneys. Furthermore, there are some situations where we know for certain that patients will die within days if they do not receive an organ transplant. This gives us at least a *prima facie* reason to prioritise the patient facing imminent death.

Some theorists argue that an urgency criterion is unjust, as candidates miss out on transplants despite having been on the waiting list for a long period of time. Tom Koch, for example, states that, "If justice and fairness are desirable elements in this process, it would seem that a higher value must be given to "time waiting," irrespective of the relative urgency of a competing patient's condition".⁵⁴ The thought is that the fairness of a waiting list should be placed ahead of considerations of medical urgency. We should, in other words, be giving first priority to those who have been on the waiting list for longer rather than those who are sicker.

This criticism raises an interesting question about the suffering experienced by persons on the waiting list. For while they might not experience death, they may still experience considerable suffering. It could be argued that, in some cases, the profound suffering that people experience is akin to death (Kamm uses the term "a living death").⁵⁵ In any case, many patients on dialysis experience a rapid deterioration in their health.⁵⁶ And so it could be argued that we should not draw a sharp distinction between death and the burden of further time waiting for a transplant.

⁵⁴ Tom Koch. "Normative and prescriptive criteria: the efficacy of organ transplantation allocation protocols". *Theoretical Medicine and Bioethics* 17 (1996): 75-93; 83.

⁵⁵ Kamm 1998, 251.

⁵⁶ Robert Veatch, Lainie F. Ross. *Transplantation Ethics* (2nd ed.). Washington DC: Georgetown University Press, 2015: 286.

This view, however, seems implausible. Death would generally be, in the case of middle age persons with life experiences ahead of them, a more serious harm than any form of physiological or psychological suffering.⁵⁷ We should, then, prioritise the patient most in need where there is a good likelihood that we will be able to provide transplants to other eligible patients in the future. The other patients who do not receive a transplant now may experience significant suffering in the interim. But it is unlikely that they will die on the registry before they receive a transplant. In light of this, they are not deserving of the same level of priority as the patient facing imminent death. In any case, it is unclear that someone who has been on a waiting list for longer *deserves* an organ more than other candidates. John and Millum observe that the “amount of time someone has waited is often involuntary or in no way morally commendable”. A waiting list “is as likely to track societal privilege or the amount of free time someone has as desert”.⁵⁸ Insofar as this is the case, a waiting list is of limited relevance to determining who is more deserving of a transplant.

We must, however, be cautious about the way in which we define medical urgency. For the more broad the definition of the concept is, the more patients who will classify as urgent and will be allowed to jump the queue. In Australia, liver-transplant candidates listed as “urgent” are typically those who face death within a matter of days or weeks.⁵⁹ There are also different categories of urgency, such that patients “at risk of imminent death” receive priority over other very ill patients who nevertheless may still be able to be kept alive for a number of days or

⁵⁷ Cf. John Broome. “The badness of death and the goodness of life”. In Ben Bradley, Fred Feldman, Jens Johansson (eds.). *The Oxford Handbook of Philosophy of Death*. London: Oxford University Press, 2012. I will not delve into the voluminous literature on the badness of death. It will hopefully suffice to appeal to our pre-theoretical intuitions regarding the harm of death.

⁵⁸ Tyler John, Joseph Millum. “First come, first served?”. *Ethics* (forthcoming).

⁵⁹ TSANZ 2017, 61-62.

weeks.⁶⁰ But urgency listing is taken very seriously, and clinicians are conscious of their duties of fairness to other patients who are on the waiting list.

4. Alternative criteria for allocation

So far we have considered how existing organ allocation protocols compare with a rationing framework focused on respect for persons. Many scholars, however, argue that current allocation protocols lead to an inefficient or inequitable allocation of resources. As stated in the introduction of this chapter, there is a burgeoning academic literature challenging the egalitarian ethos of extant allocation protocols. In this section, I will evaluate recent proposals in the healthcare resource allocation literature arguing for rationing on the basis of lifetime egalitarian, aged-based criteria; responsibility-sensitive criteria; or utilitarian criteria. Lifetime egalitarianism, I will suggest, is in conflict with a concern to respond to the current health needs of persons. I will then consider proposals that we should adopt responsibility-sensitive criteria for rationing. I will argue that ascriptions of responsibility are difficult to make, and that there are also practical obstacles to implementing such criteria. I will conclude with a brief discussion of the use of utilitarian criteria for organ transplantation. In light of the discussion in the preceding chapters, I will here focus specifically on organ allocation rather than on general philosophical objections to alternative rationing criteria.

4.1: Lifetime egalitarianism and aged-based rationing of organs

In the previous section we discussed the role that a waiting list should play in determining prioritisation for transplantation. A waiting list is, nevertheless, not the only fairness-based criterion that one might adopt for organ allocation. Indeed, several theorists have proposed

⁶⁰ Ibid.

that organs should be rationed on the basis of egalitarian criteria related to age. That is, theorists suggest (with certain qualifications) that fairness requires that we favour younger lives in patient selection for scarce, transplantable organs. In this section I will critically evaluate these arguments, and will argue that we should *not* employ age as a criterion for the rationing of organs.

One of the most influential arguments for the rationing of organs on the basis of age is Kamm's writings. Kamm, as outlined in chapter five, argues that organs should be allocated on the basis of need. Yet she asserts that the principal criterion that we should use to assess patient need is that of "adequate conscious time alive".⁶¹ Adequate conscious time alive refers to time lived with at least a "simple" or "medically adequate" level of consciousness. Kamm suggests that the patient who has had the least adequate conscious time alive is, *ceteris paribus*, the patient most in need. It is this patient who should receive the organ transplant.

Importantly, Kamm focuses on what she calls "overall equality" (or what we labelled in chapter five "lifetime equality"). She contrasts overall equality with simultaneous equality, or equality between patients here and now.⁶² In the case of organ transplantation, most registries focus on patients' current levels of health, and allocate organs to the person with the most urgent needs.⁶³ Kamm believes, however, that fairness requires that we take into account the whole lives of agents, not just their current levels of need. She fears that focusing on current levels of need may introduce inequality in the overall lives of patients.

⁶¹ Kamm 1998, 234.

⁶² Kamm 1998, 269.

⁶³ Duff Waring. "Adequate conscious life and age-related need: Kamm's approach to patient selection". *Bioethics* 18;3 (2004): 234-248; 235.

Complete lives theorists also argue that we should ration healthcare resources based on whether patients have had the opportunity to live a complete or full life.⁶⁴ That is, these theorists argue that what matters morally in prioritising one patient over another is whether a patient has had the opportunity to live through all the milestones that characterise a complete life. According to Persad *et al*, for example, we should give greatest priority for organ transplantation to patients in the 15 to 40 year age bracket.⁶⁵ These patients are in *the prime of life* and are living through what are arguably the most important experiences and milestones of life.

The complete lives thesis and Kamm's notion of adequate conscious time alive should not be mistaken for a utilitarian approach to rationing.⁶⁶ Rather than focusing on health utility, these frameworks are aimed at ensuring that resources such as organs are allocated in a way that is *fair*. Fairness, on their view, consists in ensuring that equalisanda are distributed fairly taking into account the whole lives of persons. It is for this reason that these frameworks advocate giving greatest priority to the patient who has had the least adequate conscious time alive or least opportunity to live a complete life.

There is a fundamental difference, however, between lifetime egalitarian approaches to organ allocation and an ethic of respect for persons. Lifetime egalitarian approaches take into consideration how much of some equalisandum agents have had across the course of their lives. For example, Kamm's framework defines need in terms of the amount of adequate conscious time alive that agents have experienced. A framework focused on claims of need, in contrast, focuses on the *current* health needs of persons. It considers the extent to which a

⁶⁴ Tallman 2016, 211.

⁶⁵ Persad, Wertheimer and Emanuel 2009, 427-428.

⁶⁶ *Ibid.*, 429.

patient is experiencing ill-health or injury at present.⁶⁷ It does not focus on the past experiences of the patient nor their expected future quality of life. Rather, it takes the task of satisfying the current claims of need of patients to be of primary importance.

In practice, this means that we should *not* discriminate between organ transplantation candidates on the basis of age. While some theorists may be inclined to ration care on the basis of an equalisandum that aligns loosely with the age of a person, a framework of health need focuses specifically on the current medical needs of different patients. This framework does not consider the age of a patient, or factors such as conscious time alive or the notion of a completed life. It may be the case that organs are not typically allocated to patients above a certain age. Yet this would be for medical reasons, rather than a moral consideration related to the age of the patient. TSANZ guidelines, for example, state:

“Age is not by itself an exclusion criterion for most organs. However, the presence of multiple comorbidities in patients over 70 years of age is likely to exclude the majority of such patients from eligibility for transplantation.”⁶⁸

Crucially, it is the presence of comorbidities, rather than age itself, that would render patients ineligible for transplant on this account.

Both Kamm and Persad *et al* could respond by arguing that they are not defending age based rationing *per se*. Rather, they are arguing that organs should be rationed on the basis of a good such as conscious time alive, or alternatively, the opportunity range that a person has experienced over the course of their life. And so it is not strictly speaking the age of the patient that is the basis for disqualifying someone from receiving a transplant, though age is used as a proxy. While they may loosely overlap with age, conscious time alive or the experience of

⁶⁷ Fisher 2013, 448.

⁶⁸ TSANZ 2017, 3.

life milestones are realities that are distinct from the age of a patient. It would be unfair, then, to accuse Kamm and Persad *et al.* of defending an ageist framework for healthcare rationing.⁶⁹

These frameworks, however, would in practice systematically disadvantage older patients. This is problematic despite the fact that the basis for such rationing systems is not strictly speaking *age-based*. To be clear, Persad *et al.* discuss a practical form of rationing of organs and vaccines whereby the notion of a complete life is measured in terms of a person's age, and care is rationed accordingly. If indeed this is the case, then in practice we would systematically deny care to older persons where there is also a younger patient vying for the resource.⁷⁰ And while Kamm distinguishes conscious time alive from age,⁷¹ she acknowledges that her framework will generally favour younger of older patients. Thus, she writes:

“If we accept adequate conscious life as the measure of need, the needier will, in general, be the younger rather than the older person.”⁷²

Importantly, Kamm also argues that conscious time alive is of more value for younger people than older people. More conscious time alive means more to a younger person who has more of life to experience than an older person, or so she suggests. Kamm argues that we should, *ceteris paribus*, give greater weight to claims that younger patients make on life extension through transplantation.⁷³ All of which is to say, Kamm's framework is heavily weighted in favour of the prioritisation of younger patients.

⁶⁹ Persad, Wertheimer, Emanuel 2008, 429.

⁷⁰ Erik Nord. “Concerns for the worst off: fair innings versus severity”. *Social Science & Medicine* 60;2 (2005): 257-263.

⁷¹ Kamm 1998, 239.

⁷² *Ibid.*, 236.

⁷³ *Ibid.*, 237-238.

To reiterate, the account of need defended in this thesis focuses on the current needs of *persons*, rather than *need-over-a-lifetime*. We respect persons by distributing resources based on the strength of candidates' current claims of need. This perspective is fundamentally different from the perspective adopted by Kamm and Persad *et al.*⁷⁴ A second-personal ethic requires that we respond to the moral claims that persons make on our assistance.⁷⁵ The thought is that “the here and now imposes itself on us”, such that we should “refrain from detaching ourselves from the current complaints of persons and doing an overall life calculation”.⁷⁶ Rather than basing distribution on lifetime egalitarian considerations, we should distribute organs based on people's current needs and their current complaints.

In summary, organ allocation should not be based on age – at least insofar as we wish to respect persons. Rather, we should respond to the current claims that patients make on our assistance. While it may be that clinicians choose not to provide organs to persons of a certain age, this decision should be based on clinical facts about the low probability of success of a transplant, rather than a moral conviction that younger persons should be prioritised over older persons.

4.2: Self-inflicted illnesses and prioritisation for transplant

The previous chapter critically evaluated the use of responsibility-sensitive criteria in the rationing of lifesaving healthcare resources. Such criteria, it was argued, rely on problematic ascriptions of responsibility and would be easily subject to abuse and misapplication. This section critically evaluates arguments for integrating a desert criterion into the rationing of vital

⁷⁴ *Ibid.*, 242.

⁷⁵ Darwall 2006, 60-61.

⁷⁶ Darwall 2006, 249.

organs. Rationing of organs on the basis of responsibility for illness is incompatible with respect for persons. Patients with organ failure have a claim on receiving a transplant, and this claim is valid independent of whether one is responsible for one's poor state of health.⁷⁷

The basic claim made by proponents of responsibility-based rationing is that people who are *morally responsible* for their illness should receive less priority than those who have fallen ill through no fault of their own. Specifically, persons who are to blame for knowingly and willfully bringing about a state of illness that causes organ failure should receive decreased priority in the allocation of organs. Importantly, a distinction is made in the literature between causal and moral responsibility.⁷⁸ Causal responsibility refers to the causal role that an agent has played in bringing about some state of affairs. For example, I may cause you to fall by bumping into you. Moral responsibility, in contrast, refers to the moral culpability that an agent bears for bringing about a state of affairs. This is different from causal responsibility, insofar as it involves volition on the part of the agent, and a knowledge of the consequences of one's actions. If I willfully cause you to fall by bumping you, for example, I can be held morally responsible for any subsequent injuries you sustain. But if I bump into you as a result of losing my balance, and thus cause you to fall, then it is not immediately apparent that I can be held morally responsible for any injuries you might sustain.

Theorists agree that causal responsibility for illness is not sufficient to warrant blame. For causal responsibility does not necessarily entail moral culpability, and most people agree that moral culpability is a *sine qua non* for blaming someone for their behaviour. Yet where someone *is* morally culpable for putting themselves at risk of developing serious illness, then

⁷⁷ Denier 2005, 224-234; Rosoff 2016, 186-187.

⁷⁸ Cf. Vicky Thornton. "Who gets the liver transplant? The use of responsibility as the tie breaker". *Journal of Medical Ethics* 35 (2009): 739-742; Rebecca Brown. "Moral responsibility for (un)healthy behaviour". *Journal of Medical Ethics* 39 (2013): 695-698.

we are warranted in blaming them for the situation that they are in. The most common example used in the literature on organ allocation is that of an individual who drinks heavily for many years knowing that this behaviour will likely lead to the development of Alcohol Related Liver Disease (ARLD).⁷⁹ In the case that this person develops ARLD, the patient could be held morally culpable for falling ill insofar as they engaged in reckless behaviour for several years knowing that this might lead to liver disease. We could blame this person for the current state of affairs.

Some theorists argue that this person should receive decreased priority in conditions of scarcity.⁸⁰ Specifically, when we are dealing with two transplant candidates, one of whom bears responsibility for the illness and the other who does not, we should give priority to the latter patient.⁸¹ For the latter patient is dealing with the outcome of *brute luck*, whereas the other patient is dealing with the outcome of *option luck*. Brute luck refers to something that is outside of an agent's control, whereas option luck refers to the outcome of an agent's voluntary choices.⁸² In the case of liver disease, for example, some patients experience this pathology as a result of genetic factors, whereas others develop liver disease as a result of heavy alcohol consumption.

There are, however, several issues with this argument. First, it is not even clear how responsible heavy drinkers are for bringing about their own illness.⁸³ It may be the case that their heavy consumption of alcohol is an addictive behaviour. Theorists have argued that to

⁷⁹ See, for example, Albertsen 2016.

⁸⁰ Jeff McMahan. "Justice and liability in organ allocation". *Social Research* 74;1 (Spring 2007): 101-124.

⁸¹ Thornton 2009, 742.

⁸² Vallentyne 2002, 529-557.

⁸³ Cf. Brown 2013, 696.

some extent persons cannot be held responsible for addictive behaviours, for addictive behaviours are sometimes out of a person's control. They are no longer volitional behaviours but rather are the product of compulsion and (in the last analysis) a disease.⁸⁴ For this reason, addiction is typically classified as a disease in contemporary medical contexts rather than being seen as a moral failing.⁸⁵ Furthermore, there is a broader question of how much responsibility we ascribe to individuals and how much we ascribe to the social determinants of health. Recent research has shown a strong correlation between social factors such as location, wealth, education and so forth and basic health outcomes throughout the course of one's life.⁸⁶ This suggests that ascriptions of moral responsibility for reckless behaviour are difficult to make.

Even if it were the case that we could hold someone morally responsible for developing their illness, it is still unclear whether they should receive decreased priority because of this. It is one's moral status as a practical reasoner that is the ground of their claim on the resource.⁸⁷ Even if it is the case that a person knowingly engaged in reckless behaviour, fully aware of the risks to their health, this still does not legitimate denying them basic healthcare.

An interlocutor may reply that such a response ignores the fact that we *must* make a choice when allocating organs.⁸⁸ While it may be true that we should meet people's basic needs regardless of their responsibility for their illness, we should give priority to those who are not responsible for their ill-health. Surely it is intuitive that the non-alcoholic with liver failure

⁸⁴ Kent Berridge. "Is addiction a brain disease?". *Neuroethics* 10;1 (2017): 29-33.

⁸⁵ For a nuanced discussion of the status of addiction as a disease, see Sally Satel, Scott Lillenfield. "If addiction is not best conceptualized as a brain disease, then what kind of a disease is it?". *Neuroethics* 10;1 (2017): 19-24.

⁸⁶ Brown 2013, 696-697.

⁸⁷ Nielsen 2013, 407-416; Denier 2005, 224-234.

⁸⁸ Thornton 2009, 742.

deserves priority for a transplant over the patient with ARLD. While we should still try to meet the needs of the ARLD patient, they are not the patient most deserving of lifesaving care.

The assumption underpinning this view is that personal responsibility *becomes* relevant when we find ourselves in a situation of scarcity.⁸⁹ The presence of scarcity, however, does not extinguish or diminish the claim that persons with self-inflicted illnesses have a transplant should they urgently need one. Rather, the strength of claims is determined primarily by one's level of need. This, rather than responsibility, is the appropriate criterion for determining who should receive an organ transplant. The presence or absence of scarcity is irrelevant.

Proponents of a responsibility criterion for transplantation do not typically defend a metric of prioritisation that relies solely on responsibility. Rather, they suggest a points system, with responsibility being just one indicator of the level of priority a person should receive for a transplant.⁹⁰ Even still, I am not convinced that a responsibility criterion should play *any* role in determining the level of access that a person has to lifesaving resources. A points system still constitutes a challenge to the moral authority of practical reasoners to make claims, for it makes priority partially dependent on the culpability that one bears for one's illness. Even though it does not categorically bar anyone from accessing resources, it could make it very difficult for someone with a self-inflicted condition to receive a transplant.

4.3: Utilitarianism and organ allocation

Utilitarian approaches to rationing were discussed in detail in chapter three. I will not repeat the discussion that took place in that chapter. There are, however, a number of specific issues

⁸⁹ Thornton 2009, 742.

⁹⁰ Albertsen 2016, 330-332. See also Robert Veatch. "Just deserts?". *The Hastings Center Report* 37(3): 4–6.

in organ allocation that call for a close analysis of the way in which we employ the concept of utility. Specifically, in this section I will discuss the practice of matching kidneys with donors on the basis of age, and the provision of repeat transplants.

4.3.1: Age-based matching of kidneys

One recent proposed reform to the allocation of kidneys for transplant is that of matching good quality kidneys from younger, fitter patients with younger recipients. Younger recipients have a longer predicted life expectancy, and, therefore, are more likely to gain the full benefit that is to be had from a good quality kidney. Older patients with comorbidities, in contrast, are less likely to profit from a high quality kidney. Some commentators argue that older patients should receive kidneys that are of a lesser quality or are from older donors. As transplant surgeons Jeremy Chapman and John Kanellis note,

“Survival of younger transplant patients is most affected by the quality of the kidney, while survival of older recipients is most affected by their comorbidities and less so by the quality of the kidney”.⁹¹

Chapman and Kanellis suggest that we should adjust current allocation algorithms to take into account the age of recipients, and to match donor kidneys with recipients of a similar age. Age-based matching of organs is already taking place to some extent in countries such as the US.⁹²

The fundamental ethical issue is whether it is appropriate to give older patients poorer quality kidneys on account of the decreased likelihood that they will need a kidney that functions for a very long period of time. Surgeons note that older patients are more likely to die as a result

⁹¹ Chapman and Kanellis 2018, 243.

⁹² UNOS. “Two-year analysis shows effects of kidney allocation system”. *UNOS Newsroom* 11th July 2017. Available from www.unos.org/two-year-analysis-shows-effects-of-kidney-allocation-system/.

of comorbidities than to die as a result of organ failure. Furthermore, a random allocation system

“would lose lives by allocating low quality kidneys to young people, and would lose years of functioning kidney transplants through transplantation of excellent kidneys to people with a shorter prognosis due to comorbidity”.⁹³

We should, therefore, consider if it is fair to match younger organs with younger recipients.

Importantly, we are not choosing whether someone receives a resource or not, but rather whether someone receives a resource of a better or worse quality. Strictly speaking, this is not a tragic choice situation, insofar as the person receiving the poor quality kidney will not face imminent death.⁹⁴ Rather, their life will be extended at least in the short term. As such, we need not be concerned about violating the equally strong claims that persons have on lifesaving resources.

From the perspective of a criterion of health need, then, age-based matching would seem to be acceptable, at least insofar as there was little chance of older patients outliving the expected functioning time of the kidney. For insofar as this is the case, we could argue that these patients do not really have a claim on a better kidney over a worse kidney, *ceteris paribus*. If it is the case, however, that we will be shortening the lives of older persons by giving them damaged or weak kidneys, then there would be cause for concern. An older person could legitimately complain if they received a resource that at best would only help them for a limited period of time.

4.3.2: Repeat transplants

⁹³ Chapman and Kanellis 2018, 242.

⁹⁴ Barry Hoffmaster, Cliff Hooker. “Tragic choices and moral compromise: the ethics of allocating kidneys for transplantation”. *The Milbank Quarterly* 91;3 (2013): 528-557.

It is fitting to conclude with a consideration of whether patients in need of another transplant should receive the same level of priority as patients yet to receive their first transplant. Often it is the case that patients who have received an initial transplant will experience organ failure after a certain number of years. These patients need another transplant if they are to survive. Currently in the United States and Australia, retransplantation patients who are put back on the register receive the same level of priority as patients who have not received their first transplant.

Theorists have argued in recent years that this egalitarian approach to retransplantation is problematic – both from the perspective of fairness and utility.⁹⁵ It is problematic insofar as it seems fair, *ceteris paribus*, to give priority to those who have not yet received a first transplant over those who have already received an organ. Yet current policies are blind to whether a patient has already been the recipient of a transplant. The criterion is also said to be problematic from the perspective of utility as patients in need of another organ transplant typically have higher mortality rates. As such, it is medically inefficient to allocate them organs rather than prioritising first-time transplant candidates.

The proposal is, admittedly, more modest than some might be inclined to argue for. It could be argued that persons who have already received a transplant should not be readmitted to a transplantation registry. Yet the policy proposal under consideration is only that we should use past medical history as a tie-breaker criterion when patients are equally in need of a transplant. As such, one might argue that this policy is not in direct conflict with a criterion of need.

⁹⁵ Peter Ubel, Robert Arnold, Arthur Caplan. "Rationing failure: the ethical lessons of the retransplantation of scarce vital organs". *JAMA* 270;20 (1993): 2469-2474.

Nevertheless, both of the justifications provided for this proposal are incompatible with a framework of respect for persons. The appeal to fairness is predicated on a consideration of the past medical history of candidates. Respect requires, however, that we distribute resources according to patients' current complaints. One's current right to healthcare is not vitiated on account of the medical care that one has received in the past. One cannot alienate one's entitlement to basic healthcare. Rather, the right to healthcare is grounded in one's capacity for making claims, and it remains in place regardless of the levels of access to healthcare that one has enjoyed in the past. Similarly, a utilitarian framework seeks to maximise the utility obtained from healthcare resources. This framework is insensitive to the interests of persons, and rather seeks to produce states of affairs that contain maximal utility. We should resist the temptation to ration organs on this basis. Provided that patients have a sufficient capacity to benefit from re-transplantation, they should have the same chance of receiving a transplant as any other patient.⁹⁶

Conclusion

In this chapter I have discussed a range of ethical issues pertaining to the allocation of vital organs under conditions of scarcity. I considered the extent to which new proposals for the rationing of vital organs show due respect for the moral standing of persons. Many of these new proposals, I have argued, do not show due respect for the enduring claim that persons in need have on lifesaving healthcare resources. A needs-based criterion for allocation, in contrast, respects persons, as it does not presuppose that human beings can forfeit their right to healthcare. Rather, it directs us to allocate resources such as organs on the basis of the

⁹⁶ We should not, of course, ignore relevant medical considerations about the capacity to benefit of retransplant candidates. Sometimes the likelihood of retransplantation success is very low. In these cases, a transplant could legitimately be withheld from a patient. Cf. Heidi Goerler *et al.* "Cardiac retransplantation: is it justified in times of critical donor organ shortage? Long-term single-center experience". *Cardio-Thoracic Surgery* 34;6 (2008): 1185-1190.

seriousness and urgency of the needs of candidates. Some aspects of current allocation protocols are worthy of reconsideration, such as the benefit thresholds that patients must meet to be eligible for a transplant. Current benefit thresholds would appear to be based on a utilitarian judgement rather than a consideration of patient need. Yet in general, current allocation systems have an egalitarian ethos, and this should be preserved despite campaigns to introduce age-based, responsibility-sensitive or utilitarian criteria for rationing.

In the next chapter, I will discuss a separate resource allocation issue that has certain parallels with the organ allocation debate. This is, namely, the allocation of vaccines and treatment in a pandemic scenario. Like organs, vaccines may make the difference between life and death for persons who are particularly susceptible to viral infection. Furthermore, vaccines will always be exceedingly scarce in a pandemic scenario, as limited amounts of vaccine are stockpiled by health authorities. It is vital, therefore, that we critically evaluate how vaccines would be allocated based on existing allocation protocols.

Chapter 8: The Allocation of Vaccines and Treatment in an Influenza Pandemic

So far we have considered how a framework of need applies to one widely-discussed domain of healthcare resource allocation – the allocation of vital organs under conditions of scarcity. This chapter considers a very different scenario, namely, the allocation of vaccine and treatment in an influenza pandemic. Vaccine allocation raises new but relevant questions concerning the practical implementation of a framework of respect for persons. One salient difference is that organ allocation discussions typically focus on which individual should receive a transplant, whereas vaccine allocation discussions focus on different population groups. Another key difference is that organ transplantation is a treatment, whereas vaccination is a prophylactic measure. In vaccination we are dealing with people who are relatively healthy, whereas candidates for organ allocation are already very ill.

This chapter responds to several recent proposals in the literature to radically revise allocation protocols for influenza pandemics. Current vaccine allocation protocols mandate a prioritisation of people in *at-risk/high-risk groups*, such as persons who are very old, very young, or suffering from health conditions that put them at greater risk of influenza morbidity and mortality.¹ But contemporary authors argue that we should prioritise younger and healthier members of the population, rather than prioritising vulnerable groups.² Younger persons, it is

¹ See, for example, Cabinet Office. *Preparing for Pandemic Influenza: Guidance for Local Planners*. London: Cabinet Office, 2013; US Department of Health and Human Services. *HHS Pandemic Influenza Plan*. Washington DC: Department of Health and Human Services, 2005; US Department of Health and Human Services. *Pandemic Influenza Plan: 2017 Update*. Washington DC: Department of Health and Human Services, 2017; Cabinet Office. *Guidance: Pandemic Flu*. London: UK Government, 2017. Available from <https://www.gov.uk/guidance/pandemic-flu>.

² Ezekiel Emanuel, Alan Wertheimer. "Who should get influenza vaccine when not all can?". *Science* 312 (2006): 854-855; Mark A. Miller *et al.* "Prioritization of influenza pandemic vaccination to minimize years of life lost". *The Journal of Infectious Diseases* 198;3 (2008): 305–311; 309.

argued, have more of their life ahead of them, and stand to lose more should they be infected and die from the virus.³ It is also argued that persons with health conditions for which they could be held responsible should not be given priority access to prophylaxis, for they have knowingly put themselves at risk of illness.⁴ I will argue against revising allocation protocols, however, on the basis that our primary ethical criterion for rationing should be the strength of people's claims of need.

The first section of this chapter introduces the basic elements of a pandemic scenario and highlights relevant ethical issues. It considers the guidance that a framework of respect for persons could provide in such a scenario. The different dimensions of health need in a pandemic scenario are discussed. It is argued that we have strong ethical justification for providing priority prophylaxis to healthcare workers responsible for the disaster response. After offering a critique of utilitarian and egalitarian frameworks for the allocation of vaccine in a pandemic, this chapter critically evaluates ethical frameworks for the provision of treatment for persons infected with the virus. An egalitarian approach to ICU admission and the provision of life-support is defended.

1. A basic overview of influenza pandemics

A pandemic is an outbreak of an infectious disease that is spread across a large region (such as a nation or a continent). Influenza pandemics are perhaps the most common examples of this form of healthcare crisis. Influenza affects communities worldwide every year, and on

³ Kelsey Gipe, Samuel Kerstein. "Let us be fair to 5-year-olds: priority for the young in the allocation of scarce health resources". *Public Health Ethics* 11;3 (2018): 325-335.

⁴ Chris Kaposy, Natalie Bandrauk. "Prioritizing vaccine access for vulnerable but stigmatized groups". *Public Health Ethics* 5;3 (2012): 283-295; 287. See also Kristy Buccieri, Stephen Gaetz. "Ethical Vaccine Distribution Planning for Pandemic Influenza: Prioritizing Homeless and Hard-to-Reach Populations". *Public Health Ethics* 6;2 (2013): 185–196.

occasion more severe strains of the virus arise that have the potential of spreading through whole communities and causing widespread loss of life. The H5N1 (avian flu) virus, for example, is highly lethal and thought by epidemiologists to have the potential of rapidly spreading through a community due to its highly contagious nature. Outbreaks of the H1N1 influenza virus (so-called “swine flu”) have occurred frequently around the world over the past two decades, and there is ongoing concern about future outbreaks. There are also several other human influenza strains that are said to have the capacity for causing a global pandemic.

It is often thought that viral pandemics have the greatest impact on the youngest and oldest members of the population as these persons are most immunologically vulnerable. Influenza pandemics, however, can in some cases have the most severe impact on middle aged persons. Some strains of the virus, such as H2N2 and H3N2, have had a “y-shaped” mortality curve. This was the case in the 1957 and 1968 influenza pandemics, which killed tens of thousands of people worldwide. The majority of deaths in these instances were among the elderly and those with high-risk conditions.⁵ But some pandemics can have a “w-shaped” mortality curve, affecting middle-aged persons as much as the young and the old. The 1918 H1N1 (Spanish flu) epidemic had a high rate of death among young adults aged 20 to 40 years. Similarly, the 2009 H1N1 influenza pandemic had a “w-shaped” mortality curve, with the vast majority of deaths (65%) occurring in the 18 to 65 age bracket.⁶

Importantly, pandemics can affect both developed and developing countries. Many of the major pandemics around the world in recent years have occurred in developing countries. Still, authorities acknowledge the legitimate threat of such outbreaks spreading to developed

⁵ Richard Kent Zimmerman. “Rationing of influenza vaccine during a pandemic: ethical analyses”. *Vaccine* 25; 11 (2007): 2019-2026; 2020-2021.

⁶ Kang Yiu Lai *et al.* “The w-shaped mortality-age distribution of novel H1N1 influenza virus helps reconstruct the second wave of pandemic 1918 Spanish flu”. *Journal of Pulmonary and Respiratory Medicine* 5 (2015): 1-17.

countries. The 2009 H1N1 pandemic, for example, involved an outbreak that began in Mexico but that quickly spread to southwest United States and then shortly after to Canada. And while the 2013 to 2016 West Africa Ebola outbreak did not become a pandemic, isolated cases of Ebola were reported in Western nations such as the United States, Spain, Germany, France and the United Kingdom.⁷

In anticipation of a possible influenza outbreak, authorities are stockpiling vaccines for different virulent strains of influenza. The US, for example, has enough H5N1 vaccine to inoculate up to 20 million people.⁸ There is also an international effort to increase the operational capacity of vaccine production facilities around the world. A 2016 study of global vaccine production capacity found that “pandemic influenza vaccine production capacity is at its highest recorded levels”, and that “there has been a global increase of pandemic influenza vaccine production capacity from 6.2 billion doses in 2013 to 6.4 billion doses in 2015”.⁹ Invariably, however, the amount of vaccine being produced is insufficient for the whole population to be vaccinated. Difficult decisions, therefore, must be made between which population groups to prioritise for vaccination.

In general, current allocation protocols focus on saving the most lives, rather than seeking to save those who are youngest or of greater “social worth”. Thus, extant US and UK pandemic vaccination policies prioritise the provision of vaccine to frontline healthcare workers and those

⁷ Cordelia Coltart *et al.* “The Ebola outbreak 2013-2016: old lessons for new epidemics”. *Philosophical Transactions of the Royal Society of London: Series B, Biological Sciences* 372 (2017): 1-24.

⁸ Gail Roche. “Flu vaccine, stored for pandemic risk, found safe, immunologic”. *MD* 24th January 2019. Available from www.mdmag.com/medical-news/flu-vaccine-stored-for-pandemic-risk-found-safe-immunogenic.

⁹ Kenneth McLean *et al.* “The 2015 global production capacity of seasonal and pandemic influenza vaccine”. *Vaccine* 34;45 (2016): 5410-5413.

in clinically “at-risk groups”.¹⁰ “At-risk groups” are those who due to their health, age, social situation or other factors are at greater risk of contracting the virus and suffering its full effects. The US guidelines explicitly prioritise the elderly, the very young, and people with conditions that place them at greater risk of infection. The group that receives least priority on US National Vaccine Advisory Committee and Advisory Committee on Immunisation Practices guidelines are individuals aged 2 to 64 years old.¹¹

Guidelines also sometimes prioritise healthcare workers and first responders, as well as law enforcement officers.¹² The rationale behind this is that healthcare workers and first responders will be necessary to coordinate the public health response to the pandemic, and so should be inoculated first. Similarly, it is necessary to have a healthy group of first responders across the country ready to assist healthcare workers to administer the vaccine. Law enforcement officers are necessary to ensure public order so that health workers are not impeded in their work.

2. Allocation of vaccines on the basis of need

This section considers the ethical guidance that a framework of health need provides for the allocation of vaccines during an influenza pandemic. One basic question that we must consider is “who is most in need?”. This requires that we consider how risk relates to a person’s needs, and how factors such as age, comorbidities, and social situation impact upon the severity and urgency of a person’s needs.¹³

¹⁰ Cabinet Office. *Preparing for Pandemic Influenza: Guidance for Local Planners*. London: Cabinet Office, 2013; US Department of Health and Human Services 2017, 23.

¹¹ McClean *et al* 2016, 14.

¹² See, for example, Health and Human Services 2005, 14.

¹³ Rosoff 2016, 8-17.

In chapter three, we discussed how the idea of probability impacted on the extent to which a person could be said to be in need. It was argued that, insofar as a person had a small though non-negligible probability of benefitting from treatment, that person could be said to be in need of the treatment in question. Beyond this, capacity to benefit is not relevant to our conception of need. It may have a bearing on how we choose to allocate resources. For example, a minimum benefit threshold may be introduced as an eligibility criterion for organ transplantation. But it does not affect how much a patient can be said to be in *need* of treatment or prophylaxis. As Persad *et al.* observe, it would be misleading to “claim that sick people with a small but clear chance of benefit do not have a medical need”.¹⁴

The question we must consider here, however, is whether a person’s level of need increases or decreases depending on their probability of contracting and dying from a potentially life threatening illness. For different persons may be more susceptible to contracting an influenza virus than others, and also more susceptible to succumbing to the virus should they contract it. To be clear, there is a distinction between the risk of someone contracting an illness and the risk of someone dying from an illness. The former consideration pertains to the likelihood of a person being infected by the virus, whereas the latter pertains to the severity of the harm should it occur.¹⁵

Both of these factors are constituent features of a person’s level of need. If a person is at greater risk of contracting a serious disease, then it makes sense to say that they are in greater

¹⁴ Persad, Wertheimer and Emanuel 2008, 425.

¹⁵ Cf. Satoshi Fukuyama, Yoshihiro Kawaoka. “The pathogenesis of influenza virus infections: the contributions of virus and host factors”. *Current Opinion in Immunology* 23;4 (2011): 481-486; Peter Horby *et al.* “The role of host genetics in susceptibility to influenza: a systematic review”. *PLoS One* 7;3 (2012): e33180.

need of prophylaxis. And if a person is at greater risk of harm from the disease, it also makes sense to say that their need for prophylaxis is greater. Need, in other words, is a function *both* of a person's risk of being infected *and* a person's risk of experiencing harm once they have contracted the virus.

We should, then, take into account these different factors when determining which patients have the greatest need for prophylaxis. First we should take into account factors that increase people's likelihood of being infected. For example, some persons are at greater risk of contracting the virus as a result of geographical and social factors. Persons in densely populated areas, homeless persons, and prison populations, for example, are all groups that are at greater risk of contracting the virus.¹⁶ In the next section we will also consider how a person's professional role can put someone at a greater likelihood of infection.

Second, we should take into account the likelihood that someone will face morbidity and mortality if infected. Specifically, very old and very young persons are often particularly vulnerable to complications, though middle-aged persons may in some pandemics be just as much at risk. It is necessary that we take into account the mortality curve of the virus.¹⁷ Persons who have existing health conditions may also have an increased risk of mortality if infected. Controversially, this includes persons who, due to lifestyle factors, have placed themselves at greater risk of contracting the virus.

BOX 1: FACTORS AFFECTING A PERSON'S NEED FOR VIRAL PROPHYLAXIS

¹⁶ Sonja Hutchins *et al.* "Protecting vulnerable populations from pandemic influenza in the United States: a strategic imperative". *American Journal of Public Health* 99 (2009): 243-248.

¹⁷ Zimmermann 2007, 2020-2021; Julie L. McCauley *et al.* "Host immunological factors enhancing mortality of young adults during the 1918 influenza pandemic". *Frontiers in Immunology* 6 (2015): 1-7.

FACTORS THAT INCREASE RISK OF INFECTION	FACTORS THAT INCREASE MORBIDITY AND MORTALITY
Geographic factors (e.g., proximity to the epicentre of viral outbreak)	Age
Social factors (e.g., homelessness, incarceration)	Presence of comorbidities (e.g., lung and heart disease)
Professional role (e.g., frontline healthcare workers)	Other immunological factors (e.g., sex-related factors, malnutrition causing immunodeficiency) ¹⁸

Our system of prioritisation for prophylaxis should be based on these factors. The person who receives greatest priority should be the person who is most at risk of both infection and complications subsequent to infection. And so a person who is both old and homeless, for example, or someone who lives near the epicentre of the outbreak and has Chronic Obstructive Pulmonary Disease (COPD), should receive priority access to prophylaxis. It could be argued that we should take into account whether someone has a self-inflicted illness that puts them at greater risk (for heavy smokers with COPD). In the later sections of the chapter, however, it will be argued that we should *not* deprioritise smokers, heavy drinkers, or persons suffering from obesity.

An interlocutor might argue that everyone in the vicinity of an outbreak is at significant risk of infection. As such, everyone has a very serious need of prophylaxis, and we should distribute

¹⁸ Sabra Klein. "Sex influences immune responses to viruses, and efficacy of prophylaxis and therapeutic treatments for viral diseases". *Bioessays* 34;12 (2012): 1050-1059.

resources in an egalitarian manner among candidates. The thought is that the entire population in a certain geographic area is at significant risk of morbidity (and perhaps mortality) when we are dealing with a particularly virulent strain of influenza. Provided someone is sufficiently at risk of being infected by the virus, then they should have an equal chance of accessing the vaccine to everyone else. We should, then, treat all members of the population in the same way, and distribute vaccines using a random allocation mechanism or some similar means.¹⁹

I will address strict egalitarian arguments in favour of rationing in a later section of this chapter. Suffice to say that a strict egalitarian approach would mean that we did not give priority to the worst off. Rather, we should give everyone an equal chance of accessing the vaccine. This kind of approach is problematic from the perspective of a framework of respect for persons, for on this framework we should be giving priority to those persons who are worst off. But on a strict egalitarian approach, we would not be able to discriminate between persons who would experience only minor symptoms if infected and those who faced a real threat of mortality. Yet this would be in conflict with priority for the worst off, and would also be an inefficient use of resources.²⁰ The strict egalitarian approach may, however, be justifiable in situations where we are dealing with an influenza strand so virulent that it poses a serious threat to the lives of most citizens.

The approach defended in this chapter – a vaccination policy that gives greatest priority to those most at risk²¹ – is compatible with current government policies for vaccine allocation in

¹⁹ McLachlan 2012, 317-318.

²⁰ Alistair Wardrope. "Scarce vaccine supplies in an influenza pandemic should not be distributed randomly: reply to McLachlan". *Journal of Medical Ethics* 38;12 (2012): 765-767.

²¹ By "risk" I have in mind both those most at risk of contracting the disease, and those most risk of morbidity and mortality should they contract the disease.

the UK, US, and other countries. Like these policies, it advocates the prioritisation of at-risk groups such as persons over 65 and those who are very young. Importantly, my reasons for prioritising at-risk groups is not to save the most lives. Rather, we should prioritise these groups because they represent the populations with the greatest health needs. The later sections of this chapter will discuss how a concern to meet the needs of the worst off differs from a desire to minimise loss of life. I will consider how my framework conflicts with a utilitarian approach to healthcare rationing.

3. The prioritisation of healthcare workers for vaccination

It is appropriate to consider whether we should prioritise frontline healthcare workers for vaccination. Frontline healthcare workers are responsible for implementing the public health response to disasters. If they are infected with the disease, there is a risk that the vaccination of the community will be impeded or, worse, completely undermined. There is, therefore, an important question about whether and to what extent these healthcare workers should be given priority access to vaccination.

There is strong utilitarian justification for providing frontline healthcare workers with priority access to prophylaxis. Without these workers, we will not be able to minimise loss of life and morbidity. Related to this, if healthcare workers fall ill, they may serve as “vectors [for the virus] due to their unique exposures to vulnerable patients”.²² Furthermore, there are also economic costs if the public health response fails, as massive loss of life will mean a massive loss of economic productivity. We have good utilitarian justification, then, for inoculating healthcare workers first.²³

²² Rosoff 2012, 5.

²³ Marcel Verweij. “Moral principles for allocating scarce medical resources in an influenza pandemic”. *Journal of Bioethical Inquiry* 6;2 (2009): 159-169; 166.

There are also non-consequentialist arguments in favour of prioritising frontline healthcare workers. As Marcel Verweij observes, these workers take a significant personal risk in potentially exposing themselves to the virus when providing vaccine.²⁴ As such, it could be argued that society has a reciprocal duty to give priority access to vaccine to these healthcare workers. Society is indebted to health care workers for providing healthcare under difficult conditions. To give them access to the vaccine represents an acknowledgement of the contribution that these workers make to the health of the population.

There is also, however, a needs-based justification for prioritising healthcare workers. Specifically, it seems fair to take into account the greater likelihood of these workers becoming infected with the virus. For as part of their professional role they will be in contact with large numbers of persons, and it is possible (perhaps probable) that one or more of these vaccine recipients will already be carrying the virus. As such, they have a high likelihood of coming into contact with persons infected by the virus, and thus have a high likelihood of contracting the virus. We have a needs-based reason, then, to prioritise frontline healthcare workers. My definition of need, outlined in the previous section, is a function of a person's risk of contracting the virus as well as their risk of experiencing harm from the virus once infected. Healthcare workers have a higher likelihood of contracting the virus, and therefore *need* priority access to prophylaxis.

It could be argued that the risk of infection faced by healthcare workers does not amount to a real health need. Healthcare workers are voluntarily putting themselves at risk of infection. This is different from the biological vulnerabilities that older persons and other at risk groups have. For healthcare workers, the risk level is a function of their behavior. Yet for others, the

²⁴ Ibid., 165.

risk arises from their age and health state. This is an entrenched, biological health need, unlike the artificially created 'need' that healthcare workers have because of their professional role.²⁵

But health needs are multidimensional, and they have both a biological and sociological dimension.²⁶ As such, it would be wrongheaded to dismiss the unique health needs that healthcare workers have by virtue of their occupation. Certainly, it seems wrong to hold healthcare workers responsible for the risks involved in their job. If anything, we should be seeking to compensate them for the risks that they expose themselves to. One could perhaps even extend the concept of respect for persons to apply to the unique risk-involving roles that some persons have in a pandemic response. We respect front-line healthcare by reciprocating the commitment they make to the health of others.

There is, however, a question about how inclusive we make the notion of priority for those involved in the public health response to a pandemic. For there are other professions that play an important role in allowing an orderly public health response to occur. Consider, for example, persons involved in the maintenance of law and order, or those involved in the provision of other basic services.²⁷ There is a legitimate question of whether persons in these professions deserve priority access to prophylaxis as well. The danger of being too inclusive in our list of essential services is that we prioritise professions that only play an indirect role in assisting the public health response. This could, according to Rosoff, "debase the fairness in any adopted allocation scheme".²⁸ We need to think seriously, then, about how much emphasis we want to place on social utility when determining priorities for vaccination.

²⁵ Cf. Stephen McLeod. "Absolute biological needs". *Bioethics* 28;6 (2014): 293-301.

²⁶ Allen Andrew Alvarez. "The cross-cultural importance of satisfying basic needs". *Bioethics* 23;9 (2009): 486-496.

²⁷ The HHS pandemic influenza plan gives priority to public safety workers, utility workers, transport workers, and those involved in telecommunications/IT. See Health and Human Services 2005, 13-14.

²⁸ Rosoff 2012, 5.

4. Utilitarianism and vaccination in a pandemic scenario

In previous chapters we have discussed a *save the most lives* principle for rationing. It is apposite to critically evaluate the application of this principle to vaccine allocation, for it is often used as a justification for public health policies. I will also consider another utilitarian approach to rationing, namely, a *life years saved* approach. I will argue that this approach to prioritisation shows a disregard for the moral worth of persons. Finally, I will briefly discuss theories that advocate the prioritisation of persons on the basis of social utility.

A save-the-most-lives principle has very different foundations to a rationing framework based on health needs. As discussed in chapter three, a save-the-most-lives principle is a utilitarian principle. Unlike forms of utilitarianism focused on wellbeing, the focus of a save the most lives principle is on maximising numbers of lives saved. I objected to this principle, as it mandated the prioritisation of persons with the greatest likelihood of survival where a choice must be made between two persons facing a prospect of death. Provided that patients met a basic threshold of capacity to benefit from treatment, I would argue that we should distinguish the patients on the basis of the severity and urgency of their health needs (for example, we should consider which patient is facing a more proximate risk of death).²⁹ Where we cannot distinguish patients on this basis, we should employ egalitarian tie-breaker criteria such as a waiting list or a lottery.

Yet in the context of the allocation of vaccines, a save-the-most-lives principle coincides with the recommendations that arise from the application of a framework of need. Like a framework of need, a save-the-most-lives principle would direct us to prioritise at-risk groups such as age

²⁹ White *et al.* 2009, 132-138.

groups that are most likely to face complications and death as a result of infection with the virus. Similarly, a save-the-most-lives principle would lead us to prioritise the vaccination of healthcare workers. It tracks the risk of death that different persons face, and leads us to prioritise those persons who face the greatest likelihood of death should they not receive vaccination. I would not object, therefore, to the implementation of this principle in the context of vaccine allocation (at least insofar as there is “overlapping consensus” with a framework of need).³⁰

There are, however, other utilitarian allocation policies that are objectionable. Specifically, an allocation framework based on life years saved is problematic. Some theorists have advocated an approach to rationing based on life years saved, for such an approach is seen as being a more efficient use of vaccine, and one that is sensitive to the mortality curves of influenza pandemics that disproportionately affect younger persons.³¹ A life years saved approach would prioritise the group of persons who stand to gain the most in life years should they receive the vaccine and not suffer mortality as a result of the illness. Crucially, a life years saved metric is weighted toward persons who are very young and those who are middle aged. As Miller *et al* state, a Life Years Saved (LYS) metric “values’ the prevention of the death of a younger person more highly”,³² as those who are old do not stand to gain as great an increase in life years should they be vaccinated. Saving the life of older persons, then, would count for less on a LYS metric.³³

³⁰ Rawls 1999, 340. See also Rosamond Rhodes. “Justice, medicine and medical care”. *The American Journal of Bioethics* 1;2 (2001): 32-33.

³¹ Miller *et al*. 2008, 305-311.

³² *Ibid.*, 306. See also Mark S. Stein. “The distribution of life-saving medical resources: equality, life expectancy, and choice behind the veil”. *Social Philosophy and Policy* 19;2 (2002): 212-245.

³³ Proponents of an LYS metric also cite studies suggesting that vaccination is less effective in older persons. That is, older persons are less likely to benefit from vaccination and survive a pandemic. This is arguably another reason to give weighted value to the lives of younger persons. See, for example, Katherine Goodwin *et al*. “Antibody response to influenza vaccination in the elderly: a quantitative review”. *Vaccine* 24 (2006):1159–1169.

One can understand the concerns motivating proponents of a LYS metric. Yet such a framework conflicts with prioritisation on the basis of need. A framework focused on health need would prioritise the group of persons who are at greatest risk of infection, morbidity and mortality during an influenza pandemic. In some cases this will be middle aged patients, as some pandemics disproportionately affect middle aged persons. In other cases, however, it will be the very young and the very old. Essentially, prioritisation would shift depending on who has the greatest need of prophylaxis in the particular pandemic.

A LYS metric, in contrast, is always weighted towards those who are younger. Saving the life of a younger person is of greater value according to a LYS metric. This varied valuing of lives is problematic from the perspective of respect for persons. For a framework of respect for persons attributes the same moral value to the lives of all persons; what matters is not age but rather the fact that persons have “the authority to make claims and demands on one another as free and rational agents”.³⁴ Granted, we can treat persons differently based on the strength of the claims they make on resources. Yet this differential treatment should be based on who is most in need, not who has the greatest capacity to benefit or who is younger.³⁵

A proponent of the LYS approach might argue that older persons are not necessarily disadvantaged. An LYS metric prioritises different age groups depending on the mortality curve of the pandemic. Miller *et al* have conducted an analysis of the mortality curve of three pandemics that occurred in the 20th century.³⁶ For a 1918 Spanish Flu pandemic scenario,

³⁴ Darwall 2004, 43. See also Joel Feinberg. “The nature and value of rights”. *The Journal of Value Inquiry* 4 (1970): 245-257; 252.

³⁵ Cf. Ventilator Document Workgroup. *Ethical Considerations for Decision Making Regarding the Allocation of Mechanical Ventilators During a Severe Influenza Pandemic or Other Public Health Emergency*. Atlanta: Centers for Disease Control and Prevention, 2011.

³⁶ Miller *et al* 2008, 306-308.

they recommend prioritising patients under the age of 45 years old. For a 1968 pandemic scenario, they recommend prioritising people aged 45-64 years old, while for a 1957 scenario they recommend prioritising people over the age of 45. And so it need not be the case that older persons are always disadvantaged.

This may be true, but it remains the case that older persons *may* be disadvantaged despite having the greatest level of need. Ultimately, the life years saved approach constitutes a fundamental shift in perspective. As Miller *et al* write, “these new considerations all shift attention away from seniors and toward either younger adults or children as more cost-effective targets”.³⁷ The system is deliberately weighted toward younger persons, and primarily for financial reasons. This utilitarian approach is unacceptable from the perspective of an ethic of respect for persons. It focuses on effectiveness rather than the strength of claims.

To be clear, a criterion of need is not insensitive to the unique epidemiological profile of different pandemics. Rather, it directs us to prioritise those age groups that are at greatest risk of mortality should they not receive the vaccine. As such, a needs-based framework would allow for the prioritisation of persons under the age of 45 in a Spanish Flu pandemic scenario. The difference lies in the *moral justification* given for such prioritisation. Unlike a life years saved approach, the reason for prioritising younger patients is because of their higher likelihood of mortality. It is need, not capacity to benefit, that matters in this situation.

Finally, it is appropriate to consider whether we should be rationing vaccine on the basis of the social utility of recipients. As discussed earlier, there seems to be good reason to prioritise health care workers in light of their important social role. But it could be argued that the same logic leads us to prioritise other persons who occupy important social positions, such as

³⁷ Miller *et al* 2008, 309.

positions of influence in government and law. Insofar as these persons are of important social value, and play a role in maintaining order in society, it seems that we should give them priority access to vaccine.³⁸ For example, it may be the case that we have utilitarian reasons to provide better care to political leaders, as they are a source of political stability in society.³⁹ If we fail to prioritise these persons, we may lose the social order that is necessary to carry out an effective and coordinated response to the pandemic.⁴⁰

Strictly speaking, a framework of respect for persons does not provide justification for the prioritisation of persons for treatment on the basis of their social utility. Rather, a criterion of need is responsive to the degree to which a person faces some significant health-related-harm should they not receive access to a scarce intervention. Earlier I acknowledged the right of healthcare workers to priority prophylaxis. My reasoning behind this, however, was that these healthcare workers have a greater risk of contracting the virus, and thus are in greater need of prophylaxis. This same reasoning cannot be applied to persons in positions of power in politics and law. While such persons may play an important role in ensuring an orderly response to the pandemic, there is no needs-based justification for giving them priority.

There is still, nevertheless, a question as to whether a person's social utility should play any role in determining whether they receive priority access to vaccine.⁴¹ The fact that someone is a government leader does not alter the strength of the claim of need that they make on resources. But there is a social utilitarian justification for giving these persons priority access

³⁸ Cf. Lippert-Rasmussen, Lauridsen 2010, 242.

³⁹ Cf. Health and Human Services 2005, 13: "Preserving decision-making capacity also critical for managing and implementing a response".

⁴⁰ Cf. Stone 2007, 278.

⁴¹ Jessica Du Toit, Joseph Millum. "Are indirect health benefits relevant to health care allocation decisions?". *Journal of Medicine and Philosophy* 41;5 (2016): 540-557.

to vaccine. This is, namely, that government leaders will help coordinate the response to the pandemic, and will play an important role in maintaining social stability particularly in disaster situations. As such, there is certainly a social utilitarian argument to be made for giving government leaders priority access to prophylaxis.

While I will not provide an exhaustive account of the professions that are worthy of prioritisation, I can nevertheless gesture towards circumstances in which the prioritisation of those responsible for the provision of government, law and order, and other essential services would be justified. One valid justification would be that there is a clear and demonstrable connection between the prioritisation of these persons and meeting the health needs of the general population. If a service plays an important direct or indirect role in facilitating the response to the pandemic, then prioritisation of the persons who provide this service could be justified in terms of the goal of meeting health needs. Yet the service need not relate to the public health response to the pandemic. Arguably, if someone performs a role in society that services other basic needs of persons – such as providing food or shelter for persons, or forms of healthcare other than vaccination or emergency care – then such a person is deserving of priority access to vaccine. While meeting people's health needs is our primary aim with vaccination, there is also an ancillary aim of helping society to continue to function and allowing people to have their other basic needs met in the midst of a pandemic.

It is important, however, to bear in mind the caveats raised in chapter four. An emphasis on social utility can introduce problematic inequalities in the delivery of healthcare. We should not, then, provide preferential treatment to persons just because of their social standing. Rather, prioritisation should be justifiable in terms of the broader aims of vaccination. It is only when someone will make a significant contribution to the broader public health response to a

pandemic that they should receive priority vaccination. This policy should be strictly enforced, as there is a risk of powerful persons using their influence to gain access to vaccine.⁴²

5. Egalitarian approaches to rationing

In this section I will discuss two egalitarian frameworks for the rationing of vaccines in a pandemic scenario. The first is a framework that rations healthcare resources on a strict egalitarian basis. That is, some theorists argue that we should allocate vaccines on the basis of a lottery that reflects the impartial attitude of the state toward each of its citizens. The second approach is one that gives priority to those persons who have not yet had the opportunity to live a full or complete life.

It is conceivable, though unlikely, that a political theorist might subscribe to a theory of strict equality, *viz.*, that everyone should have an equal chance of accessing scarce healthcare resources, regardless of the severity and urgency of their needs. From this perspective, it could be argued that the state should adopt an attitude of impartiality when deciding which groups it will vaccinate. For equality requires that the state does not unfairly favour one group over another. One might suggest, then, that the state should allocate vaccines by means of a lottery in which everyone has an equal chance of receiving prophylaxis.⁴³ Such an approach does not favour persons on the basis of social utility, level of need or any other factor. It is strictly impartial between different individuals.

This approach, nevertheless, relies on a problematic conception of fairness and equality. Essentially, the claim being made is that fairness requires that all persons get the same, or, at

⁴² Waltzer 1983; Persad, Wertheimer, Emanuel 2009, 424.

⁴³ McLachlan 2012, 317-318.

least, have the same chance of accessing a resource. But this ignores the fact that some persons are worse off than others, and, as such, have a greater claim on the resource than others.⁴⁴ In these situations, it is appropriate to give priority to those persons who are worst off. This is perfectly compatible with fairness and impartiality. For when we impartially consider the claims of all the persons vying for a resource, some of those claims present themselves as being of greater importance than others.⁴⁵ As Nagel writes, “the claims on our impartial concern of an individual who is badly-off present themselves as having some priority over the claims of each individual who is better off: as being ahead in the queue, so to speak”.⁴⁶ In light of this, it is actually a *requirement* of justice that we treat different cases differently, and give greater weight to claims that are manifestly more important than others.⁴⁷

Hugh McLachlan suggests that this approach merely seeks to maximise the number of lives saved during a pandemic.⁴⁸ Yet the maximisation of lives saved is not, strictly speaking, a requirement of justice. Justice only requires that we distribute vaccine in such a way that everyone has an equal chance of receiving a dose. The State is not responsible for the outcome of the distribution in terms of lives saved. Indeed, if we must choose between saving lives and acting in accord with justice, we should pursue justice. Thus, McLachlan states that, “the State should not make a trade-off between acting justly and saving lives”.⁴⁹

This would, however, be a misreading of the argument. The claim is not that vaccine should be distributed so as to maximise lives saved. Rather, the claim is that vaccine should be

⁴⁴ Cf. Wardrope 2012, 765-767. For a similar argument, see Rosoff 2012, 1-9.

⁴⁵ Ben Saunders. “Equality in the allocation of scarce vaccines”. *Les Ateliers de l'éthique* (forthcoming).

⁴⁶ Nagel 1991, 69.

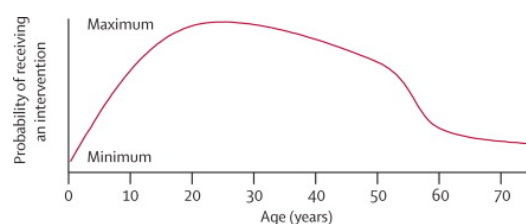
⁴⁷ Cf. Aristotle *Nicomachean Ethics*, V.3. 1131a10-b15; *Politics*, III.9.1280 a8-15, III. 12. 1282b18-23.

⁴⁸ McLachlan 2012, 318.

⁴⁹ *Ibid.*

distributed on the basis of the needs of patients. Insofar as a person has a higher risk of dying from the virus, they have a stronger claim on the vaccine in question. And as such, they should receive access to the vaccine. This framework may have the effect of saving more lives than other rationing policies. Yet this is not a necessary outcome for the framework to be considered acceptable. Persons should be prioritised on the strength of their claims, regardless of whether this maximises the number of lives saved.

This should suffice for a discussion of standard egalitarian approaches to vaccine rationing. An alternative egalitarian framework is the complete lives approach to vaccine allocation.⁵⁰ The complete lives theory, as discussed in chapter 5, is a theory of distributive justice according to which we should prioritise those persons who have had the least opportunity to accomplish significant life goals. Patients who are yet to pass through the main milestones of life stand to lose the most should they not receive vaccine and die as a result of illness. A complete lives framework also considers how invested people are in their own lives. As such, it gives greatest priority to persons in adolescence, as they have their entire lives still ahead of them, and have “more developed interests, hopes, and plans”⁵¹ than persons who are younger than them.⁵²



⁵⁰ Emanuel and Wertheimer 2006; Persad, Wertheimer and Emanuel 2008; Tallman 2014, 207-213; Kelsey Gipe, Samuel Kerstein. “Let us be fair to 5-year-olds: priority for the young in the allocation of scarce health care resources”. *Public Health Ethics* 11;3 (2018): 325-335.

⁵¹ Emanuel and Wertheimer 2006, 855.

⁵² Gipe and Kerstein (2018, 428) argue against the investment adjusted version of the complete lives framework. They argue that the framework is fundamentally unfair to preadolescents.

**Figure 1: Age-based priority for receiving scarce
medical interventions under the complete lives system⁵³**

A complete lives approach would, at least on Emanuel and Wertheimer's account, give greatest priority to persons who are 13 to 40 years old. This would be followed by persons aged 7 to 12 and 41 to 50, and then those aged 6 months to 6 years old and 51 to 64 years old. People who are 65 years or older would receive least priority on this framework.⁵⁴

A complete lives approach fails, however, to give due importance to the heightened risk of morbidity and mortality of certain population groups. Rather than giving priority to those persons who face greatest likelihood of mortality, the complete lives approach prioritises those who are yet to experience the significant milestones of life. But we should attend to people's claims of need regardless of whether they have lived a complete life or not. For respect for persons implies "caring for others by responding to their needs [and] promoting their well-being".⁵⁵ This should be done regardless of how old or young people are. When we are dealing with a question of how to allocate lifesaving healthcare resources, then, we should not abstract from the present and base our resource allocation on *whole life* considerations. As Kamm states,

"...we treat persons disrespectfully if we do not deal with their present pressing circumstances. It is wrong to detach ourselves sufficiently from the current complaints persons present to us to do an overall life calculation".⁵⁶

⁵³ Persad, Wertheimer, Emanuel 2008, 428.

⁵⁴ Emanuel and Wertheimer 2006, 855.

⁵⁵ Robin Dillon. "Respect and care: toward moral integration". *Canadian Journal of Philosophy* 22;1 (1992): 105-132; 116.

⁵⁶ Kamm 1998, 249.

An approach that is insensitive to the here and now treats people as if they were abstract entities spread across time. But people view the world from the present, and we should be attentive to this temporally situated point of view.

A complete lives theorist could acknowledge the importance of meeting health needs, but nevertheless argue that in situations of scarcity we have no choice but to make decisions between people facing a serious threat to their lives. In this situation, a plausible response would be to prioritise patients on the basis of a modified youngest first framework. The alternative approach will ultimately disadvantage those persons who are in the prime of life.

I still do not find this view convincing. In situations of scarcity, the persons who should receive greatest priority are those who face the greatest risk of loss of life should they contract the disease. In most influenza pandemics, this will be those persons who are very elderly and very young. The complete lives framework, however, systematically disadvantages older persons and those who are very young.⁵⁷ Proponents of this view consciously choose *not* to consider the greater level of risk of death faced by these groups.⁵⁸ Or, they argue that the persons “who have greatest medical need are those who have not yet had complete lives and who can benefit substantially”.⁵⁹ This is in direct conflict with a framework sensitive to *current* health needs rather than lifetime needs or a person’s capacity to benefit. The complete lives framework fails to give due importance to the claims of those who are *currently* worst off.

6. Personal responsibility, blame, and vaccination

⁵⁷ Cf. Gipe and Kerstein 2018, 333-334.

⁵⁸ Persad, Emanuel, Wertheimer 2008, 424-425;

⁵⁹ Govind Persad, Alan Wertheimer, Ezekiel Emanuel. “Standing by our principles: meaningful guidance, moral foundations, and multi-principle methodology in medical scarcity”. *The American Journal of Bioethics* 10;4 (2010): 46-48; 47.

Finally, it is appropriate to consider whether we should allocate vaccines based on a desert criterion. As discussed in chapter 6, many theorists believe that there are circumstances in which people should be held accountable for illnesses that are self-inflicted. One consequence of this is that they may not receive priority access to prophylaxis or treatment, despite their heightened risk of morbidity and mortality. A related ethical issue that we should consider is whether prison populations should receive priority access to vaccines. Some theorists argue that considerations of moral responsibility and justice counsel against providing priority access to prophylaxis for prisoners.⁶⁰

Persons who are obese or have a history of heavy smoking are considered to be at greater risk of suffering complications from an influenza infection should they contract the virus. Obesity makes someone more prone to heart-related complications, whereas a history of heavy smoking can make people more prone to developing pulmonary illness and breathing problems. Persons who fit either of these profiles are more likely to require hospitalisation, and, it appears, face a greater likelihood of mortality.⁶¹ Vaccination protocols will often list the conditions associated with heavy smoking and obesity (such as lung and heart disease) as high risk conditions for which a person should be prioritised in our response to a pandemic.⁶² Other protocols list obesity itself as an ‘at-risk’ condition.⁶³

⁶⁰ Chris Kaposy, Natalie Bandrauk. “Prioritizing vaccine access for vulnerable but stigmatized groups”. *Public Health Ethics* 5;3 (2012): 283-295; 285-286.

⁶¹ Surendra Karki *et al.* “Association between body mass index and laboratory-confirmed influenza in middle aged and older adults: a prospective cohort study”. *International Journal of Obesity* 42 (2018): 1480-1488; Lefei Han *et al.* “Smoking and influenza-associated morbidity and mortality: A systematic review and meta-analysis”. *Epidemiology* 30;3 (2019): 405-417.

⁶² Cf. Centers for Disease Control and Prevention. *Interim Updated Planning Guidance on Allocating and Targeting Pandemic Influenza Vaccine During and Influenza Pandemic*. Washington DC: Department of Health and Human Services, 2018, 25.

⁶³ Queensland Government. *Queensland Health Pandemic Influenza Plan*. Brisbane: Department of Health, 2018: 22.

In response to the suggestion that we should introduce responsibility-sensitive criteria into rationing, I have argued that we should not consider whether one is responsible for their illness when deciding who should receive access to treatment. First, it is very difficult to identify what behaviours play a causal role in the development of illness, yet alone ascribe moral responsibility to persons who engaged in those behaviours. Second, even if we could ascribe moral blame to persons for developing an illness, it remains to be shown how we could implement a responsibility-sensitive policy that picks out those and only those persons who are actually responsible for their illness. For there would be many people suffering from lung disease unrelated to smoking, or heart disease unrelated to obesity. But it may be difficult to distinguish these persons from those who played some clear causal role in the development of illness.⁶⁴ There are strong reasons, therefore, to refrain from ‘de-prioritising’ persons who are obese, who have a history of smoking, or who have engaged in other behaviors that may have contributed to their illness.

Importantly, people from lower socioeconomic backgrounds are more likely to engage in smoking and unhealthy eating, precisely because of the background they come from. Statistics indicate a close correlation between poverty, social vulnerability, obesity and substance abuse.⁶⁵ Furthermore, poverty is often the result of structural inequality – an injustice that particular social groups have already suffered.⁶⁶ There are, then, multiple levels of disadvantage that characterise the background of many people with obesity or substance

⁶⁴ Leonard Fleck. *Just Caring: Health Care Rationing and Democratic Deliberation*. New York: Oxford University Press, 2009: Ch.6.

⁶⁵ Hedwig Lee *et al.* “Longitudinal associations between poverty and obesity from birth through adolescence”. *American Journal of Public Health* 104;5 (2014): 70-76; Magdalena Cerda *et al.* “The relationship between neighborhood poverty and alcohol use: estimation by marginal structural models”. *Epidemiology* 21;4 (2010): 482-489.

⁶⁶ William Goldsmith, Edward Blakely. *Separate Societies: Poverty and Inequality in US Cities*. Philadelphia: Temple University Press, 2010.

abuse problems. It is difficult to argue that people from these backgrounds are truly responsible for their illness.

A similar discussion has occurred in the literature with respect to prison populations. For there is a perception in some quarters of society that prisoners have engaged in morally blameworthy behaviour that makes them 'unworthy' of receiving priority access to vaccination.⁶⁷ Importantly, current vaccination policies may give special priority to vaccinating prisoners, because they are at greater risk of being exposed to the virus.⁶⁸ It might be thought, however, that prisoners should be punished for their criminal behaviour. And part of the punitive conditions of imprisonment might be said to include receiving decreased priority in a public health emergency. While people may agree that prisoners should not be denied healthcare altogether, it might be thought that prisoners should not receive priority over law abiding citizens.

There are a number of issues, however, with *punishing* prisoners by giving them decreased priority in the distribution of vaccinations. For one, prisoners are already being punished for their crimes through imprisonment. It would seem to be unfair (and beyond the remit of the justice system) to impose restrictions on prisoners' access to healthcare. Second, healthcare is a basic need. And basic needs are the sorts of things we should seek to meet regardless of the identity of the person in need.⁶⁹ Someone's right to basic healthcare is something that cannot be forfeited through reckless or morally objectionable behaviour.⁷⁰ Third, even if we did think there were moral reasons to deprioritise prisoners, there are strong countervailing

⁶⁷ Gerda Van't Hoff *et al.* "Prisons preparedness for pandemic flu and the ethical issues". *Public Health* 123;6 (2009): 422-425; Jean-Claude Galliard *et al.* "Prisons, prisoners and disaster". *International Journal of Disaster Risk Reduction* 1 (2012): 33-43.

⁶⁸ See, for example, Centers for Disease Control and Prevention 2018, 20.

⁶⁹ Kaposy and Bandrauk 2012, 287.

⁷⁰ Nielsen 2013, 407-416; 415; Denier 2005, 224-234; Harris 1987, 121.

pragmatic reasons for giving them priority. For vaccinating prisoners is likely to reduce the number of persons who die or are infected by the illness. As Kaposy and Bandrauk write,

“A policy of prioritized vaccination of those who are vulnerable—whether they are morally blameworthy or not—would be more likely to reduce the number of dead and seriously ill due to influenza than a policy that prioritizes on the basis of moral blame and praise, paying no heed to vulnerability”.⁷¹

There are, therefore, strong moral and prudential reasons for giving prison populations priority access to prophylaxis in a pandemic scenario.

7. The provision of intensive care for patients infected with an influenza virus

In this final section of the chapter, I will discuss the ethical principles that should inform our allocation of life-saving treatment to patients already infected by the virus. Importantly, the provision of treatment requires separate ethical consideration, as there are a number of key differences between the provision of treatment and the provision of prophylaxis. Most importantly, vaccination is reasonably effective in preventing the contraction of a virus.⁷² Intensive care, in contrast, may or may not help a patient to overcome their illness. For there are a range of factors that can negatively impact upon a person’s capacity to benefit from treatment once infected with a virulent strain of influenza. These include age, comorbidities like heart or lung disease, and the progression of the influenza infection upon admission to ICU.⁷³ Some patients are already so ill when they present to ICU that there is very little that can be done to prevent death.

⁷¹ Ibid., 289.

⁷² Cf. Michael Osterholm *et al.* Efficacy and effectiveness of influenza vaccines: a systematic review and meta-analysis. *The Lancet Infectious Diseases* 12;1 (2012): 36-44.

⁷³ Kristine Beumer *et al.* “Influenza virus and factors that are associated with ICU admission, pulmonary co-infections and ICU mortality”. *Journal of Critical Care* 50 (2019): 59-65.

In light of this, some theorists argue that we should ration intensive care on the basis of patients' capacity to benefit from treatment.⁷⁴ Intensive care beds and ventilators are very scarce in a pandemic, and it is problematic to allocate these resources to people who are unlikely to benefit from them. If we allocate beds and ventilators in a wasteful manner, people will die unnecessarily who might otherwise have been saved in ICU. Rather, we should provide access to ICU to patients who have the greatest chance of recovery should they be admitted. This approach would maximise the number of lives saved.

Yet it would be wrong to deny people care on the basis of their capacity to benefit. This is a purely utilitarian approach to healthcare rationing, and does not do justice to the claim that each person has on lifesaving care. Rather, patients should be admitted to ICU provided they have a minimal capacity to benefit from treatment. Such an approach shows appropriate respect for persons as it rations care on the basis of patients' claims of need, rather than their capacity to benefit from treatment. This approach also avoids a wasteful allocation of resources, for patients must meet a minimum benefit threshold to be eligible for treatment.

The basic question one must ask, if one accepts the idea of a minimum benefit threshold, is, namely, "what constitutes a significant and meaningful benefit from treatment?". While one should be cautious about pre-empting clinical judgement on the matter, this threshold could perhaps be defined by a reasonable prospect of short-term survival should one receive access to life-support.⁷⁵ If a patient has very little chance of survival even with life-support, then it

⁷⁴ Janet Lin, Lisa Anderson-Shaw. "Rationing of resources: ethical issues in disasters and epidemic situations". *Prehospital and Disaster Medicine* 24;3 (2009): 215-221; Tia Powell *et al.* "Allocation of ventilators in a public health disaster". *Disaster Medicine and Public Health Preparedness* 2;1 (2008): 20-26.

⁷⁵ Specifically I would argue for a definition of *survival* in terms of "a patient's short-term likelihood of surviving the acute medical episode and not by focusing on whether the patient may survive a given illness or disease in the long-term (e.g., years after the pandemic)". See New York State Task Force

would seem fair to deny them access to ICU. One could exclude from treatment “patients who will have such a low probability of survival that significant benefit is unlikely”.⁷⁶ Indeed, one professional association of respiratory care physicians has suggested that patient groups with an expected mortality of greater than 90% should be excluded.⁷⁷ But in practice, it can be difficult to tell which patients may or may not respond to treatment. As such, clinicians must think carefully about the inclusion and exclusion criteria that they use for critical care in a pandemic situation.⁷⁸ There is also a need to determine at what point life support should be removed from patients, should they prove to be unresponsive and continue to deteriorate. This would also require careful consideration.

Yet even if we adopted a threshold criterion for admission to ICU, we would still need a mechanism to choose between patients who meet this threshold where we cannot provide ICU for them all. If one adopted an egalitarian framework for rationing, it seems that two principles for rationing could be applicable here.⁷⁹ The first is the rationing of resources based on a first come, first served basis. That is, access to ICU could be provided to those persons who presented first at a hospital. A second egalitarian criterion for rationing might be a lottery principle. If we employed a lottery mechanism, we could randomly select patients for access to ICU from the pool of candidates deemed to have a minimum capacity to benefit from treatment.

on Life and the Law and the New York State Department of Health. *Ventilator Allocation Guidelines*. New York: New York Department of Health, 2015: 4.

⁷⁶ Michael D. Christian *et al.* “Triage care of the critically ill and injured during pandemics and disasters: CHEST consensus statement”. *Chest* 146;4 (2014): 61-74; 63.

⁷⁷ *Ibid.*

⁷⁸ Cf. Lawrence Schneiderman. “Defining medical futility and improving medical care”. *Journal of Bioethical Inquiry* 8 (2011): 123-131.

⁷⁹ Christian *et al* 2014, 66.

There are, however, problems associated with the implementation of a patient lottery. In the context of a pandemic, one issue is that people need to promptly access critical care if they are to survive. As such, they cannot wait for other candidates to arrive so that a lottery can be held. Rather, a decision on whether they will receive treatment must be made immediately. Another issue is that it would require of doctors that they take an aloof approach to their interaction with patients. The provision of treatment would be contingent on how a patient fared in the lottery. As such, this approach runs the risk of undermining the doctor-patient relationship.⁸⁰

In light of this, a first come, first served policy may be a preferable option. It provides us with a practicable system to ration critical care, for it responds to the immediate needs of those who present in ICU. It also allows us to deal with scarcity while not undermining the fiduciary relationship between emergency staff and those who present in their wards. ICU staff can provide critical care to any patients who present in their wards, provided that they satisfy the criteria for admission. A first come, first served policy, finally, would help to prevent unjust discrimination against minority patients, as admission would not be dependent on a controversial value judgements about whether is deserving of admission to ICU. As Nir Eyal *et al* states: "When applied consistently, this relatively impartial principle can also prevent gross discrimination".⁸¹ Provided that the principle can be applied consistently, then, a first come, first served policy is a viable and ethically defensible policy for rationing care in a pandemic scenario.

⁸⁰ Ezekiel Emanuel, Harold Schmidt, Andrew Steinmetz. "Theories and principles of rationing". *Rationing and Resource Allocation in Healthcare: Essential Readings*. New York: Oxford University Press, 2018: 136-141.

⁸¹ Nir Eyal *et al*. "Repeat triage in disaster relief: questions from Haiti". *PLoS Currents* 4 (2012): DOI: 10.1371/4fbbdec6279ec.

Granted, a first come, first served policy has its own limitations. It may favour wealthier persons with better access to healthcare facilities. Those in disadvantaged and poorly serviced areas may have very little opportunity of reaching ICU before their condition deteriorates. And a first come, first served approach would not necessarily lead to the greatest utility being obtained from ICU facilities.⁸² It is, however, a feasible egalitarian system for rationing (presuming we could safeguard the system against being exploited by wealthy persons or persons in positions of power). If theorists take equity to be more important than utility, then they have reason to adopt this approach.⁸³

There is an important question about whether we should adopt age-based criteria for the rationing of intensive care. For some policies do not provide access to ICU for patients over the age of 85 years old.⁸⁴ Furthermore, it might be argued that care should be rationed on the basis of the long term survival prospects of patients.⁸⁵ If we adopted this approach, then younger patients would be prioritised over older patients, *ceteris paribus*.

We should refrain, however, from rationing care on the basis of age. While age can be an indicator of comorbidities that make survival less likely, it is these comorbidities that we should

⁸² Cf. Leonard Fleck, Timothy Murphy. "First come, first served in the intensive care unit: always?". *Cambridge Quarterly of Healthcare Ethics* 27;1 (2018): 52-61; Ethics Subcommittee of the Advisory Committee to the Director, Centers for Disease Control and Prevention. "Ethical considerations for decision making regarding allocation of mechanical ventilators during a severe influenza pandemic or other public health emergency". Atlanta: Centers for Disease Control and Prevention, 2011: 9; Rosoff 2012, 3.

⁸³ Cf. Charles Sprung *et al.* "Recommendations for intensive care unit and hospital preparations for an influenza epidemic or mass disaster: summary report of the European Society of Intensive Care Medicine's Task Force for intensive care unit triage during an influenza epidemic or mass disaster". *Intensive Care Medicine* 36;3 (2010): 428-443; Nir Eyal *et al.* "Repeat triage in disaster relief: questions from Haiti". .

⁸⁴ Winston K. Cheung *et al.* "A multicentre evaluation of two intensive care unit triage protocols for use in an influenza pandemic". *Medical Journal of Australia* 197;3 (2012): 178-181.

⁸⁵ The New York State Department of Health guidelines counsel against this. See New York State Task Force on Life and the Law and the New York State Department of Health 2015, 4.

be considering, rather than the age of the patient. Age is only a “surrogate marker” of function.⁸⁶ Even though patients over the age of 85 would invariably have limited likelihood of surviving a virulent influenza infection, it is their underlying health state that we should base our judgement on, rather than their age. It may be that we do not treat persons of a certain age based on the low likelihood of survival, but this is different to discrimination on the basis of age *per se*.

Other considerations discussed earlier – such as social utility and responsibility sensitive criteria for rationing – might be mooted as a means to make judgements about which patients should receive access to care. Yet critical care is a form of lifesaving treatment that everyone deserves to have access to should they need it. Even in situations of scarcity, we should not invoke considerations of social disutility or personal responsibility for illness to bar people from access to ICU. The only situation in which consideration of social utility may be useful is in terms of healthcare workers and persons responsible for basic services to accommodate needs. Yet this consideration may have limited real world applicability, considering the lengthy recovery time that some may face following infection with a virulent strain of influenza.⁸⁷

Conclusion

In this chapter, I have discussed the ethics of rationing prophylaxis and treatment in an influenza pandemic scenario. I considered how a framework of need can provide guidance for the allocation of vaccines. I argued that we should prioritise healthcare workers integral to the provision of vaccines and treatment to the general population. I argued against utilitarian and egalitarian proposals for the rationing of vaccines. Despite public opinion often favouring the

⁸⁶ Rosoff 2016, 41.

⁸⁷ Cf. James Tabery *et al.* “Ethics of triage in the event of an influenza pandemic”. *Disaster Medicine and Public Health Preparedness* 2;2 (2008): 114-118.

deprioritisation of stigmatised groups, we should still provide vaccines to groups such as obese persons or prison populations on the basis of their level of need. I also considered how critical care should be rationed among those persons already affected by the disease.

While I have provided general principles for rationing in this chapter, it remains the case that the precise character of influenza pandemics remains unclear until we are actually experiencing its effects. As such, clinicians and policy makers may be required to make difficult judgements based on limited knowledge at the early stages of an outbreak. These decisions should be made in light of the egalitarian principles enumerated above, but also with a view to anticipating the various possible scenarios that may unfold.⁸⁸

⁸⁸ Cf. Nimalan Arinaminpathy *et al.* "Effective use of a limited antiviral stockpile for pandemic influenza". *Journal of Bioethical Inquiry* 6;2 (2009): 171-179.

Chapter 9: Concluding Reflections

This thesis has considered how a principle of respect for persons can guide our decision-making when allocating scarce, lifesaving healthcare resources. We respect persons by acknowledging their authority as moral agents and attending to the claims that they make on our assistance. In healthcare resource allocation, then, we should give due consideration to the claim that each moral agent makes on scarce healthcare resources. Current healthcare allocation protocols have been criticised for their broadly egalitarian ethos. But I have argued against the adoption of alternative criteria for allocation. Ultimately, alternative criteria such as utility, lifetime equality or desert have dangerous ramifications for the manner in which we value persons. These alternative criteria focus on the realisation of more equal modes of distribution or modes of distribution in which utility is maximised. Yet in doing so they fail to take seriously the legitimate claim that severely ill persons have on lifesaving healthcare resources.

This final chapter summarises the conclusions from the preceding chapters, and discusses the policy implications of a framework for allocation predicated on respect for persons. It considers how a framework of respect for persons can be applied to other lifesaving healthcare interventions as well as to non-lifesaving interventions. It also considers how we should understand the relationship between ethical theory and policy in the context of resource allocation, as there is a need to clarify how moral theory should apply to real world scenarios.

1. Respect for persons and a criterion of need

This thesis has defended the use of a criterion of need for the allocation of lifesaving healthcare resources, and has considered how this criterion applies to two concrete scenarios – the allocation of vital organs, and the allocation of prophylaxis and treatment during a

pandemic scenario. It was argued that we should *not* ration health care on the basis of criteria such as utility, age, or personal responsibility for illness. Rather, we should base our allocation decisions on an ethic of mutual accountability, and seek to satisfy the claims of need that people make on the resources in our control.¹ In situations where we cannot satisfy everyone's claims, the primary criterion we should employ for rationing is health need (understood as implying priority for those who are most in need). A criterion of need allows us to take into consideration the essential content of the claims that people make on healthcare resources.

Chapter two of this thesis outlined how a conception of respect for persons based on an ethic of mutual accountability can provide guidance for resource allocation. There are a range of criteria that are relevant to distributive justice, including desert, equality, well-being, resources and rights. Yet an ethic of mutual accountability requires that we make ourselves accountable to the claims of need that people make on the resources in our control. As Darwall writes, "the dignity of persons includes a second-personal authority to address demands for compliance with the first-order duties of respect".² The due consideration claims of need, then, should be our primary criterion for distributing lifesaving healthcare resources. We respect persons by acknowledging the claims that they make on us. Chapter two also discussed what it means to take people's moral claims *seriously*. Where conflicts arise between claims, we should consider the relative strength of each claim. The chapter concluded by considering how a criterion of need allows us to assess the relative strength of each person's claim on resources. A criterion of need provides an objective and ethically defensible standard with which to adjudicate between people's competing claims.

¹ Cf. Williams 1963, 110-131.

² Darwall 2006, 137.

In chapter three, I outlined a detailed conception of health need that can be used for making judgements about how to allocate healthcare resources. I argued that urgency and severity are the primary components of a concept of health need. These two criteria track how badly-off someone is with respect to the indices of human health. Capacity to benefit, while it may be relevant to resource allocation generally, only has minimal relevance to a concept of health need. I concluded by considering what tie-breaker criteria we might employ when we are unable to distinguish candidates on the basis of their claims of need. A lottery mechanism was defended as a legitimate, impartial means to distinguish candidates with equivalent needs. A first come, first served and waiting list policy were also discussed. These two approaches are also defensible methods for allocation, even despite the risk that they might be abused in practice.

The following three chapters dealt with alternative criteria for rationing. Chapter four focused on utilitarian criteria for rationing, including a save-the-most-lives approach, and rationing on the basis of health utility and social utility. These approaches to rationing do not give paramount importance to respecting the claims that persons make on healthcare resources. Utilitarianism seeks to produce states of affairs containing maximal utility, rather than attending to the legitimate claims that persons have on resources.

Chapter five critically evaluated fairness-based arguments in favour of age based rationing. Specifically, the chapter discussed approaches that aimed at the fair distribution of equalisanda such as life years, conscious time alive and the opportunity to live a complete life. Lifetime egalitarianism takes seriously the interests of individuals; yet it focuses on the *diachronic interests* of persons (or the interests of persons across the course of their lives) rather than their *synchronic interests* (or the interests of persons here and now). Satisfying people's current claims of need should be given priority over the fair distribution of equalisanda such as life years, conscious time alive and the opportunity to live a complete life.

Several theorists argued that our framework for healthcare rationing should include criteria that track personal responsibility for illness. Thus, in chapter six, we considered arguments for and against the penalisation of persons who bear responsibility for illnesses that require lifesaving treatment. I argued that there are a range of concerns raised by the use of responsibility sensitive criteria, such that we should not use these criteria as a means to ration lifesaving healthcare resources. In addition to theoretical concerns, it would seem exceedingly difficult in practice to enact a responsibility-based criterion for the rationing of lifesaving resources.

The final two chapters of this thesis considered how a framework of need would apply to two particular resource allocation scenarios, namely, the allocation of vital organs, and the allocation of prophylaxis and treatment in an influenza pandemic. I argued against the rationing of vital organs solely on the basis of capacity to benefit. I also criticised proposals advocating the use of age as the primary criterion for organ allocation, and the penalisation of smokers and drinkers who have developed organ failure ostensibly as a result of their reckless lifestyle. The central argument of this thesis coheres with much of the content of extant allocation policies for organ transplantation and vaccination in a pandemic. There are still, nevertheless, some points of conflict between a framework of respect for persons and extant allocation policies, as extant allocation policies tend to be predicated on a plurality of values,³ whereas a framework of need focuses specifically on the claims of need that candidates make on resources.

2. Other applications in healthcare of a framework of respect for persons

³ Cf. Robert Veatch. "Resolving conflicts among principles: ranking, balancing and specifying". *Kennedy Institute of Ethics Journal* 5;3 (1995): 199-218.

This thesis has focused specifically on the allocation of lifesaving resources among persons who are very ill or vulnerable to illness. The concept of *lifesaving healthcare resources* has served as a useful device to illustrate the implications of a principle of respect for persons in healthcare resource allocation. The way we allocate healthcare resources is closely tied to the respect we show for persons, because persons suffer and, potentially, die if they do not receive these resources. According to a framework of respect for persons, we should respect the moral authority of persons by giving due attention to the claim that each individual person has on lifesaving healthcare interventions. A criterion of need allows us to do this. It respects the moral worth of persons by rationing care on the basis of their claims of need, rather than contingent factors such as utility, age or personal responsibility.

While I have focused specifically on organ allocation, vaccination and treatment in a pandemic, a framework of respect for persons could be applied to other lifesaving healthcare interventions. For example, this framework may provide guidance for the allocation of expensive end stage cancer treatments. It may be the case that we have to ration expensive cancer drugs, such as the checkpoint inhibitor drugs Nivolumab and Ipilimumab, among advanced cancer patients. Routinely, cancer patients who have exhausted all other treatment options will be given Nivolumab and Ipilimumab with the hope of providing a marginal increase in life expectancy. A year's supply of Nivolumab costs approximately \$150,000US. When Nivolumab and Ipilimumab are prescribed together, the cost can be in excess of \$250,000US a year. The drugs are subsidised both in Australia and the US. The treatment significantly increases the life expectancy of a small minority of patients (patients on the treatment have a long-term (5+ years) survival rate of 20%), yet the effect is negligible in others.⁴

⁴ I. Glen Cohen, Norman Daniels, Nir Eyal (eds.). *Identified Versus Statistical Lives: An Interdisciplinary Perspective*. New York: Oxford University Press, 2015: 2-3.

Insofar as we wish to respect persons, we should rank patients based on the strength of their claims of need. We could, for example, set a threshold for access based on whether patients have exhausted other treatment options. Patients who meet this threshold are in absolute need of the treatment as there are no other options left for them. Presuming all patients under the threshold are terminally ill, health authorities could hold a lottery to allocate these resources to persons in the group. An alternative would be to allocate the treatments to the patients who have the lowest life expectancy without treatment. Yet this situation resembles a situation of absolute scarcity, insofar as it is unlikely that patients who miss out on treatment now will live long enough to receive treatment in the future. As such, one could argue that all eligible patients have an equivalent need of the treatment, and that we should employ a lottery or some similar mechanism.

There are also other situations where jurisdictions may face a shortage of lifesaving treatments that are otherwise readily available. In recent years, countries such as the US and Australia have faced shortages of a range of emergency treatments, including adrenaline autoinjectors (EpiPens) for persons with serious allergies.⁵ There have also been situations where governments have said that they are unable to fund certain drug treatments for all persons with a relevant illness. This has been the case in the US with drugs used to treat hepatitis-C.⁶ In these situations, a framework of health need could be applied to determine which patients should receive priority. Persons most at risk of having a severe allergic reaction, for example, could receive priority access to adrenaline autoinjectors. Similarly, persons with advanced liver disease could receive priority access to hepatitis-C treatment.

⁵ Editorial. "The epipen shortage: how has it come to this?". *The Lancet Child & Adolescent Health* 2;12 (2018): 839.

⁶ Brandy Henry. "Drug pricing and challenges to hepatitis C treatment access". *Journal of Health, Biomedicine and Law* 14 (2018): 265-283.

Importantly, this approach would differ from the approach advocated by Philip Rosoff⁷ and others.⁸ Rosoff suggests that we should prioritise the patient who has the greatest capacity to benefit from drug treatment. He states that “the foremost criterion for giving one patient access to a scarce drug over another should be demonstrable evidence of a superior clinical therapeutic effect in the selected patient”.⁹ Chapter three of this thesis, however, argued against distribution on the basis of capacity to benefit. Rather, it was suggested that we should base distribution on need – understood as a function of health shortfall and medical urgency. Capacity to benefit is relevant, but only to the extent that a patient is capable of obtaining a meaningful benefit from a lifesaving treatment.

The State, however, has a moral imperative to address macro-level problems of supply so as to avoid micro-level situations of scarcity. Inadequate government funding or supply mismanagement can lead to shortages of otherwise readily available treatments. While I have not discussed macro-level questions of healthcare funding, I would suggest that an ethic of respect for persons gives us reason to think that the State has some responsibility to provide adequate funding for expensive, lifesaving treatments for terminally ill patients. Granted, we should not be naive about the need to balance healthcare expenditure with expenditure in other sectors of the economy.¹⁰ Yet the State neglects its duties insofar as it is favourably placed to provide basic healthcare to the citizenry and it chooses not to do so.¹¹ The State

⁷ Rosoff 2012a, 1-9.

⁸ Philip Rosoff *et al.* “Coping with critical drug shortages: an ethical approach for allocating scarce resources in hospitals”. *Archives of Internal Medicine* 172;19 (2012b): 1494-1499.

⁹ Rosoff 2012a, 3.

¹⁰ For a nuanced discussion of the idea of a basic right to healthcare, see Carmen Pavel. “Healthcare: between a human and a conventional right”. *Economics & Philosophy* (2019): 1-22.

¹¹ Cf. Dan Brock. “Ethical issues in the use of cost effectiveness analysis for the prioritization of health resources”. In George Khushf (ed.) *Handbook of Bioethics*. Dordrecht: Kluwer Academic Publishers, 2004: 353-380.

would not be excused from blame if persons died as a result of resource scarcity precipitated by government mismanagement.

A related issue to this is that of health authorities refusing to fund lifesaving treatments to persons over a certain age.¹² There is evidence that rationing of surgery on the basis of age is widespread in the NHS, though not official endorsed.¹³ Some scholars, as we have seen, have advocated for governments to take into account age in deciding which surgeries they will fund. Yet, from the perspective of a framework of respect for persons, this is unacceptable. Provided these interventions would not be futile for all patients over a certain age, it is problematic to set age limits on the availability of these treatments. Rather, as I advocated in the earlier chapters of this thesis, we should ration care on the basis of a person's health profile, not on their age. It may be the case that people are not given care on the basis of comorbidities associated with age. Rationing should not, however, occur on the basis of age *per se*.

Though cursory, this brief discussion should suffice as an indication of some of the broader implications that respect for persons and a criterion of need have for the supply and rationing of lifesaving treatments. Yet it should be noted that there are other areas of healthcare to which a framework of health need could be applied. For it is not just a person's survival needs that are relevant to healthcare resource allocation. Rather, health needs also pertain to a person's quality of life and their capacity to engage in activities constitutive of a minimally decent life. As such, a framework of need can provide guidance well beyond the domain of lifesaving healthcare interventions. Drugs that bring about quality of life improvements, for example, may have to be rationed in some circumstances. In these situations, it would be

¹² Ian Dey, Neil Fraser. "Age-based rationing in the allocation of health care". *Journal of Ageing and Health* 12;4 (2000): 511-537; 521-525.

¹³ Rebecca Thomas. "Exclusive: NHS warns CCG's over 'arbitrary rationing'". *HSJ* 10th March 2017.

appropriate to consider which patients are experiencing the most debilitating symptoms as a result of their disease. This could perhaps be one metric against which we could determine which patient was most in need of the treatment in question.

More broadly, a criterion of need could be employed to determine which treatments are funded by the State, even in situations where we are not dealing with treatments for life-threatening health conditions. Rather than adopting a QALY-based metric for assessing the cost-effectiveness of funding treatments, we could attempt to determine which patients are most in need of particular treatments. We could focus specifically on the severity and urgency of their condition, and allocate treatments on this basis. Indeed, this is precisely the proposal of Hope, Osterdal and Hasman, whose work I have relied on heavily in this thesis.¹⁴

3. Normative theory and public policy

The practical application of a framework of respect for persons will depend upon how theorists understand the relationship between ethical theory and public policy. There are a range of practical considerations that must be taken into account when developing healthcare policy. Ethical theories also often do not provide us with a guide for evaluating the politically feasible options that are available to us. As John Arras observes,

“Knowing what perfect justice requires might shed little light, if any, on the sorts of questions facing us today, such as how various feasible and politically acceptable

¹⁴ Hope, Osterdal, Hausman 2010, 470-480; Andreas Hasman, Tony Hope, Lars Osterdal. “Health care need: three interpretations”. *Bioethics* 23;2 (2006): 145-156.

options might be compared and ranked as incremental steps in the direction of a just society.”¹⁵

Furthermore, abstract ethical theories sometimes fail to take into account practical and ethical considerations that should inform our resource allocation decisions.¹⁶ Many of the theories that I have critiqued arguably are too beholden to abstract conceptions of personhood and personal identity, and not sensitive enough to the current complaints of persons.

We should not, however, abandon ethical theory just because it would be difficult to bring policy into line with our considered ethical judgements. Rather, we should seek a balance between ethical theory and practical considerations, with a view to moving toward a more ethical approach to healthcare rationing.¹⁷ At a practical level, we cannot always assume that conditions are favourable and that there is strict compliance with the requirements of ethics. Yet we should still use our theory of justice as a reference point for evaluating modes of distribution. As Rawls writes, “existing institutions are to be judged in the light of [our conception of ideal justice] and held to be unjust to the extent that they depart from it without sufficient reason”.¹⁸ We should not, in other words, abandon our ideal of justice in favour of pragmatic criteria for evaluating policy.

It is instructive to consider how one might approach the stipulation of benefit thresholds for organ transplantation eligibility. The State may determine, on the basis of ethical reflection, that the minimum benefit thresholds for organ transplantation are too high, and that these

¹⁵ John Arras. “Theory and bioethics”. In Edward N. Zalta (ed.). *The Stanford Encyclopedia of Philosophy* (2016 ed.). Stanford: Stanford Metaphysics Lab, 2016. Available from www.plato.stanford.edu/archives/win2016/entries/theory-bioethics/.

¹⁶ Mark Hall. “The problem with rule based rationing”. *Journal of Medicine and Philosophy* 19;4 (1994): 315-332.

¹⁷ Cf. Zofia Stemplowska and Adam Swift. “Ideal theory and nonideal theory”. In David Estlund (ed.). *The Oxford Handbook of Political Philosophy*. London: Oxford University Press, 2012: 373-389.

¹⁸ Rawls 1999, 216.

thresholds should be adjusted to make access to transplantation more equitable. The fact that lowering eligibility thresholds may cause consternation among transplantation surgeons or the general public would not in itself be sufficient reason to refrain from lowering the relevant threshold(s). Rather, policy makers should seek to identify ways in which the concerns of surgeons or the public could be assuaged. I have argued in favour of a process of public consultation when determining what benefit thresholds should apply to treatments such as organ transplants.¹⁹ This process could be an opportunity for authorities to address some of the concerns of clinicians and the general public. It may even be that concessions are made to stakeholders who still wish to retain a high benefit threshold for eligibility for transplant. But the very idea of a change should not be surrendered on the basis of opposition among the medical profession or the general public. We should always aim to move toward a more just distribution of resources, even in situations where there is significant public resistance to this.

Ultimately, then, I am a proponent of a theoretically informed approach to practical ethics – one that does not trade in ethical principles for the sake of being sensitive to the nuances of particular scenarios. Rather than abandoning principles, I argue that we should ensure that our principles themselves are based in everyday clinical realities. This is one reason why I have given particular importance to health needs. For health need is something that forms the basis for everyday rationing at a clinical level, while also being compatible with broader normative commitments to equality and respect for persons. The language of need is just as intelligible to a clinician as it is to a moral philosopher.²⁰

Conclusion

¹⁹ Cf. Rosoff 2017, 82-85.

²⁰ Cf. Horne 2016, 588-596.

I have gestured towards some of the ways in which a framework of need could be implemented with respect to other lifesaving treatments, as well as treatments that – while not lifesaving – play an important role in meeting people’s basic health needs. I also considered some broader questions about macro-allocation policy and healthcare financing, and how we should understand the relationship between normative theory and policy. The recommendations made in this thesis may have a fairly generic character. They can, nevertheless, provide guidance for policy on transplantation and the allocation of vaccines and treatment in a pandemic scenario.

This thesis has aimed to stimulate further research into a framework for healthcare resource allocation based on respect for persons. The literature on resource allocation has critically evaluated a range of allocation dilemmas using criteria for distributive justice taken from contemporary political theory. Theorists have, however, in some cases lost sight of the centrality of the concept of respect in allocative justice. It is necessary that we revive a strong sense of the moral force behind claims of need, and seek as our primary aim in healthcare to meet people’s health needs. Other criteria should only play an ancillary role to this primary aim of healthcare. While this thesis has focused on the needs of individual patients, another kind of need has become apparent as discussion has progressed. This is, namely, the need for a radical change of emphasis in current literature on the allocation of lifesaving healthcare resources.

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