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It's Just Allocation: an Application of Parfit's Priority View

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Abstract (50 words max.): The Covid-19 pandemic brought to light ethically puzzling questions around the allocation of medical resources, and the appeal of the principle of utility. Thus, in this paper, I propose the use of Parfit's Priority View and the principle of absolute urgency as an alternative to the principle of utility.

I write this at the tail end of one of the worst waves–and perhaps not the last–of the SARS-CoV-2 virus. Indeed, we truly are living in an unprecedented epoch of which its consequences we have yet to fully comprehend. But even in this time of great uncertainty, there is one persistent, indeed, recalcitrant truth that we can be certain of: the brunt of the consequences is and continues to be *uniquely* felt by the more vulnerable members of society. To wit, Poulson et al. (2021) carried out empirical work on health outcomes based on race during the Covid-19 pandemic. The authors note that:

> Black patients were generally younger than white, were more often female, and had larger numbers of comorbidities. Compared to white patients with COVID-19, black patients had 1.4 times the risk of hospitalization, and almost twice the risk of requiring ICU care or ventilatory support after adjusting for covariates. Black patients saw a 1.36 times increased risk of death compared to white (p.125).

Such disparate outcomes between Black and White Americans should bring us pause. Yet, as will be demonstrated below, the principles that the medical community appeal to in their ethical guidelines, such as the cherished principle of utility, exacerbate such health inequities.

Thus, my primary aim in this paper is to bring to light principles that can be used to address such racial disparities, particularly as they relate to the allocation of medical resources[1] based on race. I argue that Derek Parfit's Priority View, with the addition of the principle of *absolute*

[1] Medical resources can include anything from ventilators and PPE equipment to medical devices such as heart monitor or even organs that have been donated for transplantation. This article is mostly concerned with the former.

urgency, can be invoked not only to morally justify allocation based on race, but it also can respond to practical concerns of future scarcity[2] that the principle of utility overlooks.

This paper proceeds as follows. In section I, I begin with an overview of the current state of ethics around allocation. Here we shall find that the medical community's current *modus operandi* in how they determine the allocation of resources serves to exacerbate health disparities within marginalized groups. I then critique an attempt that has been made to try and integrate concerns of equity in the allocation of medical resources. Although this attempt is heading in the right direction, I conclude that it falls short of its intended goal due to practical concerns. In section II, I introduce Derek Parfit's Priority View. In a word, the Priority View maintains that in assessments of distributive justice, what is morally salient are benefits, and that benefits matter more the worse off you are. Here I claim that the Priority View can be used both as a justification for the allocation of medical resources based on race and as a response to practical concerns of scarcity. And, finally, in section III, we conclude with some closing remarks.

I.

We shall now attempt to get a glimpse into the current state of medical ethics, especially as it relates to the allocation of medical resources. To begin this inquiry, we will look at a prominent article by Emanuel and colleagues (2021), where they outline what they take to be the most ethically sound way to determine the allocation of medical resources.[3] Their guidelines appeal to "four fundamental values," which they list as the following: "maximizing the benefits produced by scarce resources, treating people equally, promoting and rewarding instrumental

[2] Sawyer and Sroczynski show empirical evidence that there is, for example 30% less hospital beds per capita in the US and Canada, compared to countries such as Japan. How this relates to future scarcity is described later. See Sawyer, B., & Sroczynski, N. (2016). How do US health care resources compare to other countries?. *Peterson-Kaiser Health System Tracker*, *30*.

[3] The context in which they write the paper, is situated within the Covid-19 pandemic, in so called periods of Crisis of Standard of Care (CSC). This paper focuses on medical allocation in general, but because the same principles can apply in both cases, an explicit distinction is not relevant for the purposes of this paper.

value, and giving priority to the worst off" (2021, p. 2051). Maximization of benefits, which is guided by the principle of Most Lives Saved (hereafter, MLS) is understood as "saving the most individual lives or as saving the most life-years by giving priority to patients likely to survive longest after treatment" (p. 2051).[4] Instrumental value can be interpreted as prioritizing those who save others, such as health care workers. While treating people equally is understood as using "random selection, such as a lottery, or a first-come, first-served allocation" (p. 2051). And lastly, priority to the worst off, is interpreted as "giving priority either to the sickest or to younger people who will have lived the shortest lives if they die untreated" (p. 2051).

Now at first glance, it may seem as if such values are concerned with issues of health disparities. Indeed, treating people equally and giving priority to the worst off do seem like goals worth pursuing if health disparities are of primary concern. But there is one glaring omission that immediately jumps out in the authors' interpretation of these four fundamental values. That is, there is not one mention of the aforementioned health inequities that Black Americans face. A charitable interpretation of such omissions perhaps would be that their goal was to provide broad enough guidelines such that their application could cover various contexts. And moreover, the four values are not necessarily incompatible with concerns of health equity. But concerns over the guideline's generalizability in application and the fact that the values *can* be made compatible with racial equity ought not preclude one from at the very least mentioning how these values could serve as guidance to minimize health disparities among vulnerable populations. To be sure, such pressing issues cannot be ignored if there is to be at least some semblance of health equity achieved.

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[4] There is more to be said about the principle of MLS, its different interpretations, and how it works to exacerbate health disparities amongst marginalized individuals, which will be explicated in more detail below.

More than that, ignoring these concerns further entrenches harmful epistemic practices within the medical community. To wit, Manchanda, E., Couillard, C., & Sivashanker, K (2021), bring to light the implications of such harmful epistemic practices on ethical guidelines. An example of such practices can be found in the notion of "colour blindness", which is the belief that "race is no longer relevant, [and] is contradictory and harmful" (p. 1). Such beliefs are used to interpret principles such as MLS—a principle that is, according to Manchanda et al., at its core colour-blind (p. 2).

This ethos of colour-blindness has permeated through the medical community. Indeed, the authors note that many states in the US, believe that "barring consideration of race and social factors will yield a fairer outcome" (p. 2). Yet the outcomes are far from even approximating fairness. Most forms of MLS include exclusion criteria such as the likelihood of survival or a score that determines the severity of an illness, which is then used to assign priority (p. 3). But due to the socioeconomic conditions that racialized persons face,[5] they are put at a higher risk for "chronic and life-shortening conditions such as hypertension, diabetes, chronic kidney disease, and chronic obstructive pulmonary disease" (p. 3). And so consequently, criteria used in MLS "penalize people for having conditions rooted in historical and current inequities" because, the authors continue, "if maximizing life years is the prime directive" the lives of marginalized populations will be "consistently deprioritized as compared with already-advantaged groups" (3).

Manchanda et al. argue that guidelines for allocation of medical resources must not omit but instead bring racial identity to the forefront in order to capture the differences in health outcomes between populations. As such, in Sequential Organ Failure Assessments (SOFA), they

[5] See Wang, K. (2021). Housing Instability and Socioeconomic Disparities in Health: Evidence from the US Economic Recession. Journal of racial and ethnic health disparities, 1-17.

claim that specific scores could be corrected for race, such as an adjustment in creatinine levels.[6] The author's note that such a correction would "skew CSC prioritization in favour of black patients with kidney disease" (p. 3), but because these corrections are not made, they claim that we "accept the use of race-based corrections when it favors white over black patients and reject it when it would favor black over white patients" (p. 2).

Indeed, if we are concerned as we ought to be with correcting health inequities, a good place to start would be with criteria that works to further disadvantage already marginalized populations. But to propose solutions that merely skew corrections in the other direction does not come without a host of practical concerns as well. More than that, at this point, concerns of equity are simply too difficult to sell, not just within the medical community but also in the broader community at large.[7] And so, to try and suggest guidelines that would presumably exacerbate such scarcity would be an exercise in futility. Given such practical constraints, the principle of utility, which underlies MLS, becomes even more difficult to undermine especially if we make the safe assumption that there is indeed a scarcity of medical resources, particularly in the US and Canada.[8] Thus, we must find an ethical framework that not only advances a moral argument, but that also can respond to practical concerns of scarcity. I shall embark upon this task in the following section.

II.

Naturally, one of political theorists' primary concerns is what a *just* distribution of resources looks like (Rawls 1971; Nussbaum 2007; Anderson 2010). But, as Armatya Sen and

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[6] Though an increase of creatinine levels in patients tends to point towards kidney malfunction, a high creatinine concentration in Black individuals does not always correlate with kidney malfunction and is mostly associated with a higher somatic muscle mass. See Hsu, J., Johansen, K. L., Hsu, C. Y., Kaysen, G. A., & Chertow, G. M. (2008). Higher serum creatinine concentrations in black patients with chronic kidney disease: beyond nutritional status and body composition. *Clinical Journal of the American Society of Nephrology*, *3*(4), 992-997.

[7]See Fallucchi, F., Faravelli, M., & Quercia, S. (2021). Fair allocation of scarce medical resources in the time of COVID-19: what do people think?. Journal of medical ethics, 47(1), 3-6.

[8]See *supra* note 1.

many others make clear, to say that we should aim merely at an *equal* distribution of goods is not to take seriously enough just how much each individual's needs vary in content and degree. The question then that Parfit begins his inquiry with is: What does it mean to give special consideration to people that are worse off, over and above any concern of mere equality?

In *Priority or Equality* (1995), Parfit aims to make a positive contribution around the ethics of distribution, namely The Priority View. To give a brief sketch, The Priority View is a "complete moral view," that says that benefits are good, and that they matter more the worse off the people are who receive them" (1995, p. 103). To be sure, persons can have special needs that are only urgent at the moment, while there are others whose needs are more urgent if we take their lives as a whole. But for Parfit, resources should go to those that are worse off taking their lives as a whole, not to those who are worse off merely as a matter of current circumstance. So, it may be said that *current urgency* is not necessarily decisive in the Priority View. That is, when a person's well-being over her whole life is taken as the unit of measurement, and this calculation demonstrates that she is in a worse off position, a different, stronger sense of urgency emerges. This gives rise to what I shall call the principle of *absolute urgency*, which says: when distributing resources, special concern ought to be given to those that are worse off over the course of their whole lives, and thus whose needs have more *absolute urgency*.

But now we must ask why the principle of absolute urgency should take precedence over the principle of utility when distributing resources? To answer this question, let's first consider how the principle of utility cashes out in a hypothetical clinical scenario:

> *The Moderate Scarcity Example*: Person A and person B are in competition for one unit Q, where Q in this case is a medical resource, let's say a ventilator. Person A is a black individual who happens to be from a low socioeconomic neighbourhood and who has

comorbidities. Person B is white and is from a neighbourhood with higher socioeconomic status (SES). As per the results of the SOFA assessment, the ventilator is to go to Person B, since they happen to not have any comorbidities—whereas A does—and so in upholding MLS and the principle of utility, the ventilator is given to B because they will be able to take more advantage of the ventilator.

It may be said that *current urgency* is an underlying factor in this decision. Because scarcity is safely assumed, there is a sense of immediate or *current urgency* that makes MLS and the principle of utility so appealing. Indeed, if person A is given the ventilator, but because of her comorbidities, unfortunately succumbs to her illness, then this would conceivably have a downstream effect and would put a strain on the overall access to medical resources that others will have.

But why is moderate scarcity only assumed to be relevant to the *current* situation? Given what we know about the health outcomes of black populations, especially those who come from low SES backgrounds,[9] it can be argued that an appeal to current urgency would increase long term, or future scarcity. That is, if Q goes to B under MLS, indeed the *current* benefit will be maximized, but at the expense of increasing *future* scarcity. To wit, if all medical resources go to those who are in a better off position, then we put others in even worse states than they originally were. Indeed, if A were at a level of well-being five at T^2, then presumably at T^3 she would be even worse off, with a level of well-being below five. Whereas person B moves to a higher level of well-being than they already were, relative to themselves and to Person A. So, in practice, the principle of utility decreases the units of well-being for those that are worse off, while arguably only marginally increasing the units of well-being to those who were already in a better position. It follows then that an appeal to current urgency and the principle of utility would exacerbate *future*

[9] See *supra* note 7.

levels of scarcity, since vulnerable populations will be faced with worse health outcomes and others will experience only marginal increases to their prior positions. And if this is true, then this is something that the principle of utility overlooks.

On the other hand, The Priority View and the principle of *absolute urgency* does have the capacity to respond to future scarcity. But first what is needed to address this issue is to expand the principle of *absolute urgency* to also include future states of well-being. To begin, let's take a look at the statement "Sharon cares about her well-being". With this statement, we can happily infer that that "Sharon cares about her current well-being" at T^1, and moreover, that "Sharon cares about her future well-being" at T^2. Indeed, the very word itself 'well-being' is in a present-progressive tense, which in our mental grammar we understand as an event that is both presently occurring and ongoing. So, similarly, when we take the well-being of a person's life as a whole*,* to be the morally relevant unit of measurement in the Priority View, we are not just concerned with an individual's well-being at T^2, it follows that we are similarly concerned with an individual's well-being at a future state T^3.

Now, in the *Moderate Scarcity Example*, if we uphold the Priority View and the principle of *absolute urgency*, it would override *current urgency,* because in giving the resource to person A, we also address the practical concern of *future* scarcity. That is, since we are not making people worse off than they already are at their current state T^2, we thus create a more equalized, overall state of well-being, in that there would be less demand of scarce medical resources. Indeed, because B is already in a better position than B, then if A's level of well-being is raised, then it follows that overall levels of well-being would increase, which would in principle reduce *future scarcity*, since there would be less demand of resources.

Thus, the Priority View is in a better position to respond to the practical issue of moderate scarcity, because and insofar as it is concerned with the continuous well-being of individuals, whereas the principle of utility can only account for moderate scarcity in its *current* form. And so, we must conclude that The Priority View, with the addition of the principle of *absolute urgency*, can be invoked to not only morally justify allocation based on race, but also to respond to practical concerns of future scarcity.

III.

We have argued that the principle of utility cannot adequately address practical concerns and is especially not equipped to address concerns of racial equity. In its place then, we advanced the Priority View, and concluded that, with the addition of the principle of *absolute urgency*, it could address both concerns of health equity and practical concerns. Health equity concerns were addressed insofar as benefits were given to those who are worse off, where in the relevant cases, the worse off would be those at the lower end of health disparities. With respect to practical concerns, in upholding the principle of *absolute urgency*, we were able to include future states of well-being in the assessment, which allowed us to steer clear of future concerns of scarcity.

This analysis brings to light a serious concern plaguing the current state of medical ethics. Indeed, if we continue with the use of MLS, we could be responding only to *current* scarcity at the expense of *future* scarcity. The burden is then on those who employ the principle of utility in their guidelines for allocation. Indeed, they must now justify the use of a principle that is not able to respond to serious practical concerns, and concerns of racial equity. But we will not hold our breath; pointing out a default in something so widespread, is, in the words of the late author David Foster Wallace (2011),

like saying traffic is bad…nobody but ludditic granola-crunching freaks would call bad what no one can imagine being without (p. 620).

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