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Nielsen, Lasse

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DR LASSE NIELSEN (Orcid ID : 0000-0003-3093-4448)



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# Contractualist Age Rationing Under Outbreak Circumstances

**Lasse Nielson**

**Correspondence:** Philosophy, Department for the Study of Culture, University of Southern Denmark. Campusvej 55, 5230 Odense M, Denmark

Email: lasseni@sdu.dk

**Lasse Nielsen** is a philosopher and associate professor at the Department for the Study of Culture, University of Southern Denmark. He works in ethics and political philosophy, and his research interests include distributive justice, sufficientarianism, health ethics, and the capability approach.

**ABSTRACT**: Age rationing is a central issue in the health care priority-setting literature, but it has become ever more salient in the light of the Covid-19 outbreak, where health authorities in several countries have given higher priority to younger over older patients. But how is age rationing different under outbreak circumstances than under normal circumstances, and what does this difference imply for ethical theories? This is the topic of this paper. The paper argues that outbreaks such as the Covid-19 involve special circumstances that changes how age should influence our prioritization decisions, and that while this shift in circumstances poses a problem for consequentialist views such as utilitarianism and age-weighted consequentialism, contractualism is

better equipped to cope with it. The paper then offers a contractualist prudential account of age rationing under outbreak circumstances.

**Keywords**: Covid-19; Outbreak; Age rationing; Consequentialism; Contractualism; Prudential life-span account.



During the spring 2020, the Covid-19 outbreak forced health care systems into a state of extreme alertness and caused a state of emergency in a number of countries. In Italy, for example, the statistics reported around 25 thousand instances and almost 2 thousand Covid-19 related deaths by March 16. Many countries looked cautiously to Italy to learn how to deal with the situation as it arrived. Among several extraordinary initiatives resulting from the outbreak in Italy was a rather controversial decision to initiate age rationing on health care resources. On Thursday, March 12, the Italian College of Anesthesia, Analgesia, Resuscitation and Incentive Care issued new guidelines to be used in cases of extreme shortage of health care resources. The guidelines said that intensive care resources should be reserved to those who have more potential life years. Dr. Flavia Petrini, the President of the College, noted that, "these choices [e.g. age rationing] are made in normal times, but what's not normal is when you have to assist 600 people all at once".[1] Consequently, the Italian health care authority decided to not offer intensive care to Covid-19 patients over age 65, later to be revised to patients over age 60. The Italian experience suggests that the Covid-19 circumstances for health care prioritization are special in a way that makes age rationing especially morally justified and possibly even morally required.

The extent to which age rationing of outbreak health care resources is necessary will depend on how well a nation's health system is prepared to cope with the outbreak situation, which in part depends on its political context. Certainly, many will say in retrospect that the Italian health system was inadequately prepared to tackle the Covid-19 situation and that this is largely explained by previous political arrangements. Similarly, many will blame the political system of other countries—such as the UK—for not taking the necessary and timely precautions. While this is certainly an important lesson learned from the Covid-19 experience, I will set it aside in this paper and focus on the ethics of age rationing in outbreak health care allocation situations.

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[1] Horowitz, J. (2020). Italy's Health Care System Groans Under Coronavirus – a Warning to the World. *The New York Times*, March 12. Retrieved from https://www.nytimes.com/2020/03/12/world/europe/12italy-coronavirus-health-care.html.

Although age rationing seems reasonable in the Italian case, many find it extremely controversial in part because it seems on a standard interpretation to involve age discrimination.[2] This raises the question to be dealt with in this paper. How is age rationing different under outbreak circumstances than under normal circumstances, and what does this difference imply for ethical theories? I argue that outbreaks such as the Covid-19 involve special circumstances for the ethics of age rationing, and that a contractualist prudential account is best equipped to acknowledge and embrace this contextual shift between outbreak and non-outbreak situations.

## Age Rationing in Health Care Priority Setting

Suppose that a group of doctors can offer intensive care to one of the following two patients:

A) a 20-year-old with 60 more life-years, or
B) a 70-year-old with 10 more life-years.

Call this *the original case* of age rationing. Most people believe that we should prefer A,[3] and this seems to fit the rationale of the Italian experience. Many health-professionals, however, would be reluctant to accept this rationale as standard for clinical practice. And in the public debate on Covid-19 related health care allocation, some have objected that systematically giving priority to younger over older patients is a form of morally impermissible age discrimination.[4]

There is wide agreement in the philosophical literature that it is moral to give priority to A, but philosophers disagree on why this is so. Consequentialists take a utilitarian or prioritarian route of explanation. The utilitarian suggests treating A due to the larger gain in quality life-years and hence in overall personal welfare.[5] But while utilitarianism explains well the original case, it runs against our intuitive responses in other cases, in part because utilitarian ageism is sensitive to life-expectancy only, not age specifically. For example, utilitarian ageism would judge A and B equally

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[2] Lippert-Rasmussen, K. (2013). *Born Free and Equal?* Oxford: Oxford University Press, p. 25.

[3] Busschbach, J. J.V., Hessing, D. J. & De Charro, F.Th. (1993). The Utility of Health at Different Stages in Life: A Quantitative Approach. *Social Science and Medicine* 37(2), 153-158; Johannesen, M. & Johansson, P-O. (1997). Is the Valuation of a QALY Gained Independent of Age? Some Empirical Evidence. *Journal of Health Economics* 16(5), 589-599.

[4] Popescu, D. & Marcoci, A. (2020). Coronovirus: Allocatin ICU Beds and Ventilators Based on Age is Discriminatory. *The Conversation UK*, April 22, Retrieved from https://theconversation.com/coronavirus-allocating-icu-beds-and-ventilators-based-on-age-is-discriminatory-136459.

[5] Tänsjö, T. (2019). *Setting Health-Care Priorities: What Ethical Theories Tell Us*. Oxford: Oxford University Press.

good if the case was revised to involve the same health benefit for both patients, but most would still find it morally preferable to treat the younger, since this patient has, unlike the old, not enjoyed the benefits of previous life-years. Some consequentialists suggest prioritarian age-weighting as a way of defending the age-rationing intuition by applying the logic of weighted values from prioritarianism on age stages.[6] The age-weighted view gives the right answer in the original case, and its application of age weights solves the problems with utilitarianism. Thus, it seems a more plausible form of consequentialism, despite that it still faces its own set of limitations.[7]

Contractualist accounts can give the same answer as consequentialist theories in the original case, but for different reasons. The so-called "fair innings view", or "complete lives system", implies that we should give priority to A over B, because whereas B has already had her fair share of life-years and opportunities, this is not the case for A.[8] The fair innings view captures an important moral intuition but faces challenges stemming from its arbitrariness around the fairness threshold (e.g. 70 years of age). For example, although the fair innings view gives the intuitive answer in the original case, it cannot explain why we would give priority to treating A over B, if B was 60, not 70, years old. But this seems implausible.

Alternatively, a prudential contractualist view, often ascribed to Daniels' prudential life-span account, would explain why we should treat A over B with a hypothetical intrapersonal argument relying on the assumption that "we all age".[9] Since we would prefer for ourselves the ability to be treated for Covid-19 at 20-years of age over access to treatment at 70-years of age, we should under such circumstances prefer A over B. On the other hand, the prudential life-span account can also explain why it would be unfair to always deny treatment to elderly people for the benefit of the younger, because the "we all age" assumption implies that all live with a modal rational expectation to become elderly, and thus it would be prudent—given lack of information about one's own life-span health profile—to allocate resources such that it secures adequate

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[6] Tsuchiya, A. (2000). QALYs and Ageism: Philosophical Theories and Age Weighting. *Health Economics* 9(1), 57-68; Farrelly, C. (2008). Aging Research: Priorities and Aggregation. *Public Health Ethics* 1(3), 258-67; Bognar, G. (2008). Age Weighting. *Economics and Philosophy* 24, 167-189; Bognar, G. (2015). Fair Innings. *Bioethics* 29, 251-261.

[7] Davis, B. (2016). Fair Innings and Time-Relative Claims. *Bioethics* 30(6), 462-468.

[8] Persad, G., Wertheimer, A & Emanuel, E. J. (2009). Principles for Allocation of Scarce Medical Interventions. *The Lancet* 373(9661), 423-431; Williams, A. (1997). Intergenerational Equity: An Exploration of the Fair Innings Argument. *Health Economics* 6(2), 117-32.

[9] Daniels, N. (1993). Am I My Parents Keeper? *Midwest Studies in Philosophy* 7(1), 517-540; Daniels, N. (2008). Justice Between Adjacent Generations: Further Thoughts. *Journal of Political Philosophy* 16(4), 475-494.

opportunity in all stages of life. But the contractualist view also meets criticism. Most notably, the "we all age" assumption has been under heavy fire.[10]

Both consequentialist and contractualist accounts can plausibly explain and justify age ratioing in the original case without being unjustly discriminatory against the elderly, but on both views, this involves an inherent tension. As Bognar notes in defense of age-weighted consequentialism, "minor life extensions to many older people might outweigh extending the life of a young person by a substantial time", but due to the diminishing value of extra life-years for older people, this is a weaker discriminatory effect than the one, utilitarians give, and therefore, "much more plausible".[11] But the tension remains; in the original case, it seems intuitive that we give absolute, not merely weighted, priority to the young over the old, and this corresponds to how we react to the Italian case, but we are still reluctant to accept the conclusion that older people should always have overridden their entitlements to health care. The prudential contractualist view better explains why it is rational for us to prefer saving some health care for the last stages of life, since we all plan to grow into elderhood, and it would be unreasonable to plan for leading a senior life with no health protection, but this comes at the expense of explaining what is so special about outbreak cases that makes it suddenly justified to give absolute priority to the younger. To proceed and improve our theorizing about the role of age in health care priority setting, we need to assess the deliberation of the theories in light of their response to outbreak circumstances. I turn to this below.

## Outbreak Circumstances

Above we learned that there is an immanent tension between our intuition of giving absolute priority to the younger in the original case while allowing some space for saving resources for elderhood in general health care planning. This tension is explained by the specific conditions that make the original case similar to the circumstances of outbreak health care rationing. Thus, our theories of health care priority setting need to be contextualized so as take into account the distinction between special circumstances of outbreak scenarios such as the Covid-19 situation, and

[10] Bognar (2015) op. cit. note 6; Lazenby, H. (2011). Is Age Special? Justice, Complete Lives and the Prudential Lifespan Account. *Journal of Applied Philosophy* 28(4), 327-240.

[11] Bognar (2015) op. cit. note 6, p. 260.

life-span health care allocation. What are the ethical particulars of the outbreak circumstances that makes it different from life-span prioritization?

One relevant difference is that the outbreak scenario concentrates on actualized urgent, needs-responding health rationing. This is different from life-span health care planning in which much reasoning concerns hypothetical security. In other words, whereas life-span prioritization to a large extent involves insurance against potential health risks, the outbreak scenario presents an actual rescue case. Second, the outbreak scenario concerns mono-disease treatment allocation rather than overall health care coverage. Where life-span health care priority-setting should be concerned with all potential health risks and must be prepared to make trade-offs between different types of treatments, outbreak prioritization sets aside these general concerns and focuses narrowly on rationing the same type of health care resources. Finally, the outbreak scenario involves new and immediate critical stakes with only scarce resources. That is not to say that stakes are not high, and resources not limited, under normal health care planning circumstances, but the outbreak scenario brings new critical stakes to the priority situation which take immediate focus.

In sum, the outbreak situation is one in which the prioritization concerns actual needs-responding, mono-disease treatments where the stakes are critical and immediate. This is arguably a different ethical context than the context of life-span health care allocation. Where the latter involves considerations such as which treatments should be available and at which stages in life, the outbreak scenario asks only how we should distribute the available but scarce health care resources among the patients now in desperate need of it. In the Covid-19 situation, as we experienced in the Italian case, these harsh circumstances resulted in restrictive rationing of intensive care with the purpose of securing supply for the younger patients. Now that we have briefly sketched the particular outbreak circumstances, the question is how our ethical theories manage to adapt to them. Since the change in circumstances is arguably significant, it seems to require of ethical theories that they are able to react to the contextual shift. The next section analyzes consequentialism and contractualism in light of their ability to adapt.

## OUTBREAK CONSEQUENTIALISM

Consequentialism has problems with adapting to the outbreak circumstances. The best candidate, I have argued, is the age-weighted prioritarian view, as it does explain both why we should treat A over B in the original case, and why treatment to old people matters somewhat anyway. Under

outbreak circumstances, the age-weighted consequentialist view recommends age rationing because it matters more to treat people, the younger they are. So, the age-weighted view offers a plausible consequentialist approach to the Covid-19 case, which moreover seems consistent with a general ethical rule for health care priority setting. It may seem as if this eases the tension between specific outbreak rationing and general priority setting.

But the age-weighted consequentialist view runs into problems when elaborating its reasons for setting priorities in the specific case. To see this, consider the following consequentialist line of deliberation.

Consequentialist age-weighted deliberation
*A decision to invoke age rationing under outbreak circumstances is morally justified, because it matters more to benefit people, the younger they are.*

If we ask *why* it matters more to benefit the young, the age-weighted consequentialist would want to appeal to multiple moral reasons. One reason is the maximization of "the weighted sum of life years",[12] which implies that the number of life-years matter. But the age-weighted view, as Bognar explicitly notes, is also appealing to the fairness consideration of the fair innings intuition to justify the weight-function attached to the age-relative value. In other words, if asked why one additional life year is worth more in moral terms if given to a 20-year-old than to a 70-year-old, the consequentialist suggests that this is indeed because the younger suffers the unfairness of having had fewer life years than the older. This implies that an age-weighted consequentialist would offer the following additional elaborated reason.

Consequentialist fairness-weighting
*Treating people matters more, the younger they are, because young people have had less life-year opportunity than older people*.

But if this is the rationale, it raises the question of how fairness considerations should count against consequentialist maximization in priority-setting situations that do not involve age-weighting. As mentioned, the age-weighted consequentialist view gives the right answer in the original case but

[12] Bognar (2015) op. cit. note 6, p. 259.

consider a revised case where the choice is between treating two 20-year-olds who differ in terms of socio-economic status. Here, the age-weights are equal, but since life-expectancy follows a social gradient,[13] treatments given to people at the bottom of the social hierarchy would generally produce fewer quality life-years over a lifespan than if given to people higher up the social ladder, and thus we should expect treatment to patients with privileged socio-economic status to generate significantly more (age-weighted) life years than socially disadvantaged patients. So, suppose the age-weighted view faces the choice of offering intensive care to one of the following two patients diagnosed with Covid-19.

C) A socially privileged 20-year-old with 60 more life-years, or
D) A socially disadvantaged 20-year-old with 40 more life-years

Brute age-weighted consequentialism implies that we should prefer C over D. Since we cannot rely on differences in age, the consequentialist is now inclined to maximize (age-weighted) life years which speaks for treating C, not D. But this response disturbs our intuition of fairness as it pro tanto implies discriminating based on class. Many would find this implausible and a reason to reject the view. The original case seems to bring forward the ethical grounds for age rationing in the Covid-19 situation, but note that this revised case could easily occur under Covid-19 circumstances, yet it is implausible to insist that the Italian health authorities, for example, would have been justified in also invoking rationing that discriminated based on socioeconomics. This speaks against the consequentialist reasoning.

Maybe there are other independent consequentialist reasons that mitigate this unattractive implication. For example, since the age-weighted view owes much of its moral rationale to prioritarianism, it would be reasonable for its defenders to also accept the general line of distributive prioritarianism—i.e. that it matters more to benefit people, the worse off they are. This seems to offer a solution because D is certainly in one respect worse off than C. Thus, we could have a kind of consequentialism—call this, "prioritarian age-weighted effective prioritarianism"[14]—that simply accepts conflicting moral reasons, including age-weighted life-year maximization and

[13] Marmot, M. (2015). The Health Gap, *The Lancet* 382, 2442-2444.

[14] I think this is what most age-weighted consequentialists would indeed claim but note that there is no logical commitment between prioritarian age-weighting and distributive prioritarianism.

distributive priority-fairness, and would therefore be indeterminant in the case of choosing between C and D.

Indeterminacy seems to be an appropriate reaction to this case, but I still believe the deliberation speaks against consequentialism. We are indeterminant in the revised case of C and D *not because* the additional benefit of treating the privileged is counter-balanced by our moral duty to give special weight to the worst off, but because we find that socioeconomics have no role to play in this particular context. Recall that the outbreak scenario is one in which the prioritization concerns actual needs-responding, mono-disease treatments where the stakes are critical and immediate. Here, rationing according to socioeconomics seems completely out of the picture. Importantly, this does not imply that socio-economic factors are irrelevant for Covid-19 treatments. Certainly, vulnerability to Covid-19 also follows a social gradient due to social differences in capabilities to protect against transmission, as well as access to high-quality care etc., but the effective allocation of health care resources among people now in need of them should be socioeconomically blind, when their needs are equally urgent and stakes are equally critical.

Life-span health care planning on the other hand should not be blind to socioeconomics. This is because socio-economic status is a strong predictor for health functioning over a lifespan (e.g. through life-style diseases) and for capabilities for coping with health risks, which are important reasons to make health care prioritization socially balanced. For example, since we know that mental health problems are much more prevalent among the socially disadvantaged, we should be carefully protective of this group in our allocation of resources to prevent and treat mental diseases. Under outbreak circumstances, we want to set aside socioeconomics and give people with equal needs the same opportunity for treatment, as this is the only fair response to their immediate entitlements.

## OUTBREAK CONTRACTUALISM

Contractualism fares better. A contractualist account would explain well why we should save some resources for elderhood under standard circumstances of life-span health care planning. Since resources allocated to the elderly can be understood as hypothetical insurance against a situation in which oneself is in need of medical assistance as a result of age, and since we all plan for elderhood, it is rational to prudently spread out resources to cover a full lifespan. As argued by Daniels,

> [A] life as a complete whole does not go as well as possible if certain important needs are not met at some stage or other of the life, or if certain all-purpose means are inadequately provided at some stage or other of the life.[15]

This implies that without giving out on cost-effectiveness completely, the contractualist view can justify giving adequate priority to health care for elderly. In other words, a young person is not necessarily treated unjustly if refused treatment for a given condition for the benefit of providing health care for another condition for an older patient, even if health care for the younger's condition would be more cost-effective.

As mentioned, the "we all age" assumption has been met with criticism, and rightly so. Indeed, we do not all age; some die prematurely, and contracteers ought to be aware that birth cohorts therefore get smaller with time. But the important part of the assumption is that we do "each of us" age in the sense that we live our lives in the belief that we will live through all stages of life. This is rational, because most of us will get to live full lifespans, and even when this is not the case, it matters for many of our current projects that we live on this assumption. Part of the value for me in having children is imagining myself being a part of their lives, seeing them grow up, become teenagers, students, having careers and children of their own. Many of my imaginations will turn out to be mistaken; maybe I will die before becoming a grandparent, maybe my children will choose not to have children of their own, or maybe one of them will die prematurely. There is no way I can know, but this does not make my imaginations imprudent. Prudent lives a lived forwardly, and they can remain prudent even if they don't turn out as expected.

But under outbreak circumstances, the assumption that each of us age is set aside. Importantly, this does not prove contractualism false, it only shows that we will have to revise it according to outbreak conditions. That is, prudence must be contextualized and redefined. This is where contractualism proves more contextual and adaptable than consequentialism. What it means to maximize welfare, or live years, does not change depending on contexts. But what it means for a decision to be prudent, on the other hand, will be highly influenced by contextual circumstances. Thus, it seems that we need to look beyond universalist distributive principles and identify a contractualist procedure that is sensitive to the contextual information on which the prioritization is based. This procedure could be unfolded in the form of a prudence test like the following.

[15] Daniels (2008) op cit. note 9, p. 485-486.

Weak prudential age rationing

*A decision to invoke age rationing on health care resources is morally justified if the circumstances and contextual information on which the decision is based make it imprudent from any perspective not to favor treatment of the younger over treatment of the older.*

The weak prudential view is allowed by Daniels' contractualism, although it is quite underspecified what it more particularly implies. One problem is that the weak prudential age-rationing claim provides a mere necessary, not sufficient, condition for justification of age rationing. Consequently, while it does in fact state that age rationing will be justified when circumstances are such that dismissing it would be imprudent, it leaves open that age rationing could be justified from other ethical sources as well and therefore, it *could be* justified even if *im*prudent. Another problem with weak prudential age rationing is that does not commit to any particular, distributive implications. This is because being justified is not exclusive in the sense of making its opposition naturally unjustified. That is, while weak prudential age rationing may express why age rationing is justified, it cannot explain why this is also, sometimes, all things considered *the right thing to do*. Parallelly, it could be morally justified to donate eighty percent of one's income to charity, but it does not follow that not doing so is unjustified. In fact, many would think that there is moral justification on both sides.

Consequently, we do not learn much about how to prioritize under outbreak circumstances from the weak prudential account, and it seems that while it can take us some of the way, we need a more demanding test to flesh out a satisfactory contractualist response to outbreak health care age rationing. Hence, we arrive at a reformulation of the prudential account in a more demanding version.

Strong prudential age rationing

*A decision to invoke age rationing on health care resources is morally required, if the circumstances and contextual information on which the decision is based make it imprudent from any perspective not to favor treatment of the younger over treatment of the older.*

This view is stronger because it commits to age rationing whenever circumstances are such that not doing so would be imprudent. It says, "while we often refrain from age rationing, these particular circumstances make it imprudent, and therefore morally impermissible, not to take age into consideration". This raises the question whether it is in fact imprudent not to invoke age rationing under outbreak circumstances. This, of course, depends on what prudence pertains to.

As noted in the original work by Daniels, the contractualist account of prudence is different from pure strategic rationality. Rather than being all about computing maximization of outcome benefits, Daniels—inspired by Rawls' veil of ignorance—imagines prudence to be what rational and reasonable human persons would choose for themselves, given that they do not know about their particular interests and dispositions. Daniels believes that a reasonability account of prudence would amount to a contractualist ideal of securing for everyone a "normal opportunity range at each stage of their lives",[16] but only under circumstances of normal length lives, where the assumption that each of us age is reasonable. Thus, an important qualification of the contractualist view is that specific circumstances may undermine the prudential life-span view. "Indeed," Daniels notes, "prudential considerations that might endorse rationing by age depend on what sort of resource scarcity exists".[17] This is exactly the kind of contextual flexibility we need.

The question is then, whether it would be demanding for reasonable impartial persons to give absolute priority to treating the younger over the older patients when taking into consideration the specific outbreak circumstances. To answer this, see how the contractualist view changes when the outbreak circumstances enter the equation. First, the traditional life-span deliberation would pertain to something like the following

> Contractualist Life-Span Deliberation
> *Imagine that in the course of leading a life of normal length, you will be exposed to a number of health risks at different stages in your life. How severe and serious these risks are for you may depend on arbitrary facts of your life (e.g. socioeconomics) but also your age. You have no information available about which and when health risks appear, or about other arbitrary facts (e.g. socioeconomics), but you do know that under the assumption of normal-length lives, it is rational to lead a life as if it will pass through all different age stages.*

[16] Daniels (1993) op. cit. note 9, p. 529.

[17] Ibid: 537.

Daniels would claim that we should, following a deliberation along these lines, favor the prudential life-span account, because given these circumstances for health care planning, it is prudent to prefer an allocation of resources such that it would secure a normal opportunity range at each stage of life. My point here is that contractualism is better prepared than consequentialist theories to embrace the contextual shift in circumstances around the allocation situation. To see this, consider the circumstances of the outbreak scenario. Again, recall that the outbreak situation is one in which the prioritization concerns actual needs-responding, mono-disease treatments where the stakes are critical and immediate.

Now, compare the life-span deliberation above to the following deliberation involving outbreak circumstances.

Contractualist Outbreak Deliberation

*Imagine that at one given point in the course of your life, you will be exposed to health risks from a serious outbreak of disease causing a mono-disease state of health emergency involving health care shortage. That is, a significant loss of healthy life-years is at stake, caused by one and the same disease-entity, and there are insufficient resources. How severe and serious these risks are for you may depend on arbitrary facts of your life (e.g. socioeconomics) but also your age. You have no information available about at which stage of your life, the outbreak related health risks are actualized, or about the arbitrary facts (e.g. socioeconomics), but you do know that, under the assumption of otherwise normal-length lives, it is rational to lead a life as if it will pass through all different age stages.*

How should a prudent contracteer respond to this deliberation? I think most contractualists would hold that we should dismiss principles that discriminate based on socioeconomics. The reason is that given that stakes are critically high for everyone in need of care, and that they all need the same treatment, discriminating based on arbitrary factors would be unfair. Some contractualist might be inclined to accept a form of distributive prioritarianism—for the same reason that Rawls' veil of ignorance justifies the difference principle—which would imply some discrimination in favor of the worst off. But in my view, this is implausible under outbreak circumstances because we cannot rely on socioeconomics to determined who is worse off in this particular case. Since stakes are critical in

a sense that does not reflect socioeconomics, and the needed treatment is the same, people in need of intensive care must be considered equally badly off. Moreover, even if I am mistaken here, and contractualists would be right to insist on socially weighted prioritarianism even in the outbreak scenario, this would be compatible with my critique of how socioeconomics figured in the consequentialist deliberation.[18] Thus, my rejection of consequentialism stands.

Regardless of how contractualism would weigh socioeconomics in the outbreak scenario, it seems certain that it would have to take age into consideration. I believe that giving absolute priority to treatment at earlier stages in life over later stages in life is completely unavoidable following this deliberation. The assumption that each of us age, which is central to the life-span view under normal health care planning circumstances, is overridden by the immediate instance of the outbreak circumstances and now plays a different, and less central, role in emphasizing how the value of being treated is discounted with age. Moreover, where the life-span deliberation invites considerations of how a person is expected to function at different stages in life, as well as how one is able to cope with conditions that arise during these stages—because it involves trade-offs between treatments for different conditions over a life-course—the outbreak deliberation is narrowly focused on the opportunity-cost of not being treated which varies significantly with age. For these reasons, any rational and reasonable person would, if given the choice of either being treated for a life-threatening condition at age 20 or being treated for the same condition at age 70, prefer the former over the latter, and hence this is the prudent choice.

On the strong prudential account, giving absolute priority to the younger patient is the demanded decision *because* it is the prudent decision, and therefore it should count not only (intra-) but also interpersonally. The reason is that since age rationing under these circumstances is prudent for me, *because* I am a rational and reasonable person, it would also be prudent for you, and this is the contractualist relation between prudence and morality. If someone objects that this is a morally unjustified instance of age discrimination, and that it would be fairer to flip a coin, we should respond that this cannot be true. This is because we can justify this decision with the expectation of fifty additional healthy life years for the person in question, whoever that person will be. No such justification can be given if we decide to flip a coin.

These reflections show how the contractualist view of health care priority-setting is better equipped than its consequentialist competitors to embrace changes in contextual circumstances. The main point of the argument can be captured by stressing that the prudential account fares better

[18] I am grateful to an anonymous reviewer for pushing me to elaborate the point in this paragraph.

because prudence itself is appropriately depending on the contextual circumstances under which decisions are made. Whereas the particular context around a given rationing decision cannot change what it implies to maximize personal welfare or healthy life years, it does effective influence what prudence comes down to. For this reason, the prudential contractualist account is simplistically described when referred to as the *life-span* view. Life-span health care planning is just one instance of prudent resource allocation. Outbreak rationing is another.

Consequentialists would object that even if the contractualist account I have defended here sounds reasonable, it is in fact more consequentialist than contractualist, because it is the attraction of the additional benefit in life years that does the normative work. In other words, I have simply assumed that the contracteers are already consequentialists under a veil of ignorance. But this is false. Firstly, it is wrong to suspect that it is maximization of life years that does the normative work. If it were, the life-span deliberation would be different than it is, because here the contractualist account goes against naïve life-year maximization. Giving absolute priority to the younger patient under outbreak circumstances is morally required because the alternative does not meet our standards for prudence—which, as I have argued, can be tested intra-personally. That prudence in this particular case means weighing alternative outcomes in terms of life-year benefits against each other does not make the account a form of consequentialism.

Second, it is possible for a prudent contracteer to acknowledge life years saved as a morally relevant factor without this becoming the overarching moral driver. If the deliberation was all about numbers, the prudential account should also be willing to discriminate on a background of socioeconomic status and other factors influencing the total health and welfare outcome, but these are perfect examples of what we would find unfair to include in the equation (or at least include in the way, they figure in the consequentialist equation), and the prudential contractualist account is, thusly, quite different from any form of consequentialism.

Finally, some object that the contractualist account of age rationing on Covid-19 health care priority-setting is problematically age discriminatory nonetheless.[19] This is so, because even if we accept the assumption of a normal lifespan, the circumstances surrounding a lifespan is a social construct. Even if we do each of us age, the circumstances under which different generations age are very different. Our generation will have much better opportunities as elderly than the one before us, and the next generation will likely have even better opportunities. But this, critics conjecture,

[19] Popescu & Marcoci op. cit. note 4.

undermines the contractualist assumption that all lifespans are equal. While this highlights an important consideration for how contractualism should allocate resources—and a valuable addition to Daniels' account, especially on how to deal with intergenerational allocations—it does nothing to threaten my argument. My argument relates specifically to outbreak circumstances where the assumption that each of us age has already been compromised, and thus it should make little difference that we were hypothetically to age in different ways.

## CONCLUSION

Age rationing is controversial and it is difficult to determine when and why it is the right thing to do. However, it is an extremely important issue and the Covid-19 outbreak has turned it into a hot-button topic for health care priority-setting. In this paper, I have shown that age rationing is justified in bedside-rationing scenarios according to both consequentialist and contractualist ethical theories. I have then argued that the shift of context between life-span health care planning and outbreak rationing exposes an immanent tension in these theories. In the last part of the paper I have argued that contractualism is better equipped than consequentialism to acknowledge this contextual shift and therefore ease the tension, and I have developed a contractualist prudential account of age rationing that I believe succeeds in this endeavor. While this argument is not decisive evidence for contractualism over consequentialism, it does serve as a defense of the contractualist prudential view on the age problem in health care priority-setting.

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