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The Symposium on "Setting Health-Care Priorities" by Torbjörn Tännsjö

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Abstract: The present paper constitutes an introduction to a special issue of *Diametros* devoted to *Setting Health-Care Priorities. What Ethical Theories Tell Us* by Torbjörn Tännsjö. The book in question states that there are three moral theories which have valid implications in the field of the distribution of medical resources in a healthcare system: utilitarianism (possibly conjoined with prioritarianism), the maximin/leximin view, and egalitarianism. A number of authors have contributed to this special issue with papers which challenge this thesis. Robert E. Goodin argues that, besides general moral theories, some local principles of justice might be valid. Quinn Hiroshi Gibson states that Tännsjö should have considered the Rawlsian view on justice in its contractualist reading. Jay A. Zameska argues that his "revised lexical sufficientarianism" constitutes a more reliable moral view than prioritarianism. Finally, Lasse Nielsen points out that there is more to say about distributive justice than consequentialist theories can grasp. Moreover, he puts forward an argument in defense of prioritarianism. The final article in this issue presents Tännsjö's replies to his critics.
Keywords: local principles of justice, Rawlsian contractualism, sufficientarianism, prioritarianism, egalitarianism, maximin, leximin, dignity.

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In the book, Tännsjö appears as moral realist believing that truth in moral reasoning is attainable, utilizing our intuitions that survive through the process of acquiring full knowledge about their origin.[1] He maintains that only three ethical theories in the domain of distributive decisions can be candidates for grasping moral truth, i.e., hedonistic utilitarianism (possibly with a prioritarian amendment), the maximin/leximin theory, and egalitarianism. However only utilitarianism survives unscathed, with the author debunking some of the intuitions that seem to support the others.[2]

The rationale for hedonistic utilitarianism is the simple intuition that happiness, suffering, and pain have constant moral value irrespective of place, time, and subject in which they take place.[3] Prioritarianism is a modification of utilitarianism, one which

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[1] Tännsjö (2019): 2-4.
[2] Ibidem: 9-90.
[3] Ibidem: 21.

pays more attention to people's happiness, suffering, and pain the worse their situation is.[4] Maximin/Leximin is a much more complicated view. As Tännsjö perceives it, the theory emphasizes the separateness and integrity of persons, pointing out that there is no such thing as a 'global person' constituted by all sentient members of society. Therefore, there is also no entity which could experience the aggregate of happiness. As a result, according to maximin/leximin theory, compensation for the losses of one person by means of the gains of another is deemed to be wrong. All of this is intuitively supposed to imply the ethical rule according to which "you must focus on the person who is worst off and see to it that her life is as good as possible"[5] when making distributive decisions. The third view – egalitarianism – in Tännsjö's eyes is "a family of theories all resting on the idea that inequalities are of negative value."[6]

Although the three theories may differ in several respects when confronted with some thought experiments, according to Tännsjö they are unanimous in the assessment of the functioning of healthcare systems in developed countries. The upshot is that too many resources are spent on expensive marginal life extension interventions, especially in the elderly, while mentally ill patients do not receive enough care.[7] Tännsjö seems to believe that providing health care to mentally ill patients might be a cheaper and more beneficial action in terms of happiness than, e.g., treating life-threatening tumors in the elderly. Therefore, the first sorts of actions are justified by utilitarianism. Moreover, he upholds that younger people are those who, if treated, will usually live longer and be more able to enjoy life than the elderly.[8] Since both psychiatric patients and young patients have usually not attained as much happiness through their lives as older people, they are also more entitled to receive care under the maximin/leximin and egalitarian theories.[9] The conclusion is that all three views recommend that similar reforms need to be taken in healthcare systems.

Most of the commentators publishing in the current issue of *Diametros* have focused on theoretical aspects of Tännsjö's book. However, Robert E. Goodin is one who has also pressed the problems associated with the application of Tännsjö theories. Rather than confronting his thesis, Goodin conducted an anthropological speculation to explain possible reasons why the current organization of healthcare systems is so distant from the one recommended by Tännsjö's favored theories:

> My first suggestion is that one explanation for why too many resources are devoted to prolonging life pointlessly for terminally ill patients is that those patients are right in front of the attending physician, whereas others on whom those resources might be better spent may often not be.[10]

[4] Ibidem: 44–53, cf. Parfit (1997).
[5] Tännsjö (2019): 24, the view is inspired by John Rawls (1999): 24.
[6] Tännsjö (2019): 29, cf. Temkin (1993).
[7] Tännsjö (2019): 172–200.
[8] Ibidem: 18–20.
[9] Ibidem: 22–43.
[10] Goodin (2021): 28.

Goodin argues that patients who are right in front of physicians are more capable of lobbying for their interests than those who stay at home. This factor is strengthened through the identifiable victim effect: we are more willing to help identifiable people than care for merely 'statistical numbers'.[11] Indeed, people suffering from depression in their homes are more likely to be 'statistical numbers' for physicians than those who suffer from life-threatening conditions. As Goodin points out, the abovementioned psychological bias is sanctioned by traditional medical ethics, according to which "the physician's first and primary duty is to the patient."[12] According to Goodin, yet another factor which might explain why Western healthcare systems place such a strong emphasis on life extension is due to human psychology: "people place disproportionate weight on their experience of the endpoint."[13] The particular weight placed by people on the last moments in human life may explain why they care so much for the extension of their lives if they have unfinished business. This point made by Goodin could be perhaps pushed further by evoking Joel Feinberg's notion of ulterior interests,[14] Ronald Dworkin's critical interests,[15] or the investment interests of John Davies.[16] All of these types of interest constitute a non-hedonic part of well-being often associated with the achievement of crucial long-distance life goals.[17]

Regarding theoretical issues, Goodin raises the problem of local rules of justice which were not discussed in Tännsjö's book. According to Goodin, some of these principles might be ethically valid, yet they contradict global utilitarian, maximin/leximin or egalitarian principles. An excellent example of such a local rule is the principle of non-abandonment:

> Once you have commenced treatment, you must not cease treatment so long as it is still needed (unless the patient requests you to do so, or unless there is another physician who will take over treatment, or unless the prognosis is hopeless). Ordinarily, you do not cease caring for a less medically-needy patient, just because another more needy case arrives (although if the disparities are extreme, you might with apologies do so).[18]

This principle, as Goodin observes, clashes with utilitarianism since utilitarianism requires the abandonment of a patient if a new one arriving at the hospital might receive a more considerable benefit, and there is only one physician available for both. In his reply, Tännsjö points out that the local rules mentioned by Goodin are vague, and therefore liable for different interpretations. Moreover, the best way to argue for this kind

[11] Schelling (1984), cf. Żuradzki (2019).
[12] ACP (2012): 86.
[13] Goodin (2021): 30.
[14] Feinberg (1986): 37.
[15] Dworkin (2011).
[16] Davis (2007).
[17] For an overview of ulterior, critical, and investment interests and comparison of this kind of well-being with the hedonistic theory of wellbeing, see: Nair-Collins (2017): 528–532.
[18] For the related discussion about asymmetry between withdrawing and withholding life sustaining treatment see Wilkinson, Butcherine, Savulescu (2019), and the related commentary – Żuradzki, Nowak (2019).

of local rule is to show that it is justified by one of the global ethical theories. Tännsjö writes, "[t]he best way of defending one such principle would be to show that it has good consequences when people believe in it and use it in negotiations and rationalizations of actual medical decisions."[19] Suppose such a justification of the rule is adopted. In that case, no actual conflict with utilitarianism occurs, since the principle in question "(…) demands that patients should only be offered assisted death when it is not reasonable to treat them (considering the needs that are easier to meet from other patients)."[20]

It seems that Goodin's remarks on local rules potentially open up an exciting discussion. The justification of local principles of justice, however, is put to the side by Goodin. He writes, "I leave open for the moment what might be the relation between those global and local principles, and whether the latter might just be a special case of the former (with a little more concrete empirical texture, or some such)." Perhaps a good way for Goodin to defend local rules of justice as independent from the global theories reading is by appeal to Tännsjö's metaethical methodology. Perhaps we are entitled to refer to intuition not only as a method of the acquisition of direct moral truth in the case of answering general questions such as whether happiness is good, but also in answering many concrete questions like: is it appropriate to withdraw care for the patient that we had once started to treat?[21] If our intuitions say "no" regarding cessation of other types of treatment than palliative care, they clash with utilitarianism. Moreover, it is not so obvious that such an intuition will disappear simply because we acquire knowledge about its origin. Therefore, the conflict with utilitarianism might be an enduring one.

Other problems addressed by the contributors to the issue mainly concern the specific theoretical issues with the three theories favored by Tännsjö. Quinn Hiroshi Gibson argues that the version of the maximin/leximin theory considered by Tännsjö significantly differs from the original version of this view as developed by John Rawls. Moreover, Gibson argues that a more faithful Rawlsian theory of justice should be taken into account by Tännsjö. Gibson argues that the rationale behind the truly Rawlsian approach with its difference principle is the "contractualist idea that social arrangements need to be *justifiable to each*."[22] He observes that the metaphysical assumption about the separateness of persons cannot alone justify principles of justice adopted by Rawls. Tännsjö agrees that the hypothesis about the separateness of persons does not constitute a sufficient basis to develop an argument favoring the maximin/leximin view. According to him, given the separateness of persons, one could just as well arrive at the procedural theory of distributive justice of Robert Nozick.[23] However, Tännsjö claims, Nozick's view collapses due to its immoral consequences.[24]

Tännsjö's reply to Gibson's requirement to consider Rawlsian theory in its contractualist reading is more important. He points out that there are two types of contractualism: "one kind of contractual thinking takes place against the backdrop of moral nihilism, or at least the idea that people won't take any notice of morality anyway (…)

[19] Tännsjö (2021): 61–62.
[20] Ibidem: 62.
[21] Tropman (2017): 473–474.
[22] Gibson (2020): 15
[23] Nozick (1974).
[24] Tännsjö (2021): 64.

[a]nother take on contractualism is to see it as presenting heuristic devices in our search for plausible ethical theories."[25] In his opinion, both types of contractualism are redundant for his analysis. The first type is redundant because Tännsjö tries to answer the question about the implications of *ethical* theories. Moral nihilism does not count as such a theory, at least according to him.[26] The second type of contractualism might be more helpful. However, it is only a vague and defective device to discover true ethical theory.

Another contributor to the special issue – Lasse Nielsen – points out that consequentialism does not exhaust the whole domain of distributive justice. In his opinion, there are three essential deontological constraints on acceptable distributions of resources that Tännsjö does not grasp:

> Suppose we can find health-care resources to treat a group of young patients for a non-fatal but relevantly harmful disease, but only by taking resources currently used to maintain minimal care for elderly and patients suffering from severe dementia. Now, it is important to stress that pleasures (or hedons, as Tännsjö uses the term) are also valuable for dementia patients, but since their dementia to some extent compromises their awareness and experience of their own condition, and since they have fewer life years left in any case, we can easily imagine that it could be justified on consequentialist grounds to redistribute the resources for the benefit of the group of younger patients.[27]

Nielsen believes that human dignity has a vital role in distributive justice since it is the basis for a strong moral right to provide minimal care to every human being. Consequentialist reasons can hardly outweigh such a right. He writes: "we will not stand for the undignified treatment of anyone, regardless of how much benefit others can gain from this."[28] Tännsjö replies that according to his consequentialist approach, no one is ever denied minimal care since at least palliative care, including terminal sedation or euthanasia, has to be offered when the patient does not qualify for essentially therapeutic treatment.[29]

Another, more theoretical point made by Nielsen concerns a specific and controversial verdict about a value of life that is allegedly implied by prioritarianism:

> Think of a person whose life is threatened by a disease. If he is not treated, then he will die immediately. If he is treated, then he will live one additional year. However, there will be ups and downs during this last year. In order to stay alive, he will now and then have to go through short sessions with painful therapies. Assume that, when we sum the happiness in his remaining year, the net will be +100. However, when we add the weights given by prioritarianism, because of the extra weights given to his downs, the moral value of his additional year will be -1.[30]

[25] Ibidem: 64–65.
[26] Ibidem.
[27] Nielsen (2021): 37.
[28] Ibidem: 38.
[29] Tännsjö (2021): 66.
[30] Tannsjo (2019): 84.

According to Tännsjö, the case speaks against prioritarianism. It is unintuitive to judge that a generally happy life is not worth living. The supposed upshot is that prioritarianism can hardly be perceived as an amendment over utilitarianism. Nielsen believes that the argument provided by Tännsjö against prioritarianism might be weakened if we notice that under the utilitarian approach we can find as well some cases of life that are not worth living while having an overall positive value based on prioritarianism.[31]

Yet perhaps the problem with the controversial case depicted in the cited fragment of Tännsjö's book could be solved differently. It seems to me that Tännsjö and Nielsen both interpret prioritarianism as a theory that conflates personal moral ideals with impersonal moral ideas[32] (or personal values with impersonal values,[33] vel. agent-relative reasons with agent-neutral reasons[34]). In other words, they conflate the evaluation of the goodness of life *for a given person* with the value *for the world* of the fact that such life exists. If one keeps these types of values distinct, it is possible for prioritarians to argue that the value of life *for the person* described in the cited fragment amounts to +100. It is, in fact, a life worth living for her. The value of life for the person equals its prudential value. However, the value of such life is at the same time -1 given the impersonal perspective.[35] One could argue that such an impersonal evaluation has nothing to do with whether the described life is worth living or not for the person. The fact that it has an impersonal value on the basis of prioritarianism which amounts to -1 represents the importance of providing further help for the person in question.

The last commentary on Tännsjö's book is that of Jay A. Zameska who argues that one of the theories favored by Tännsjö has a better counterpart that was not included in the book. Namely, he states that prioritarianism should be substituted by some strong form of sufficientarianism, called "revised lexical sufficientarianism." According to this view inspired, but not limited to the thought of Roger Crisp:[36]

> A state of affairs x is better than a state of affairs y if and only if:
> 1. The number of people below the threshold is fewer in x than in y; or
> 2. The number of people below the threshold is equal in x and y, and the total shortfall from the threshold is less in x than in y; or
> 3. The number of people below the threshold is equal in x and y, and the total shortfall is equal in x and y, and the total aggregate above-threshold welfare is higher in x than y.[37]

Zameska argues that the view endorsed by him, in contrast to Tännsjö's prioritarianism, avoids a repugnant conclusion and another objection built on the following case:

[31] Nielsen (2021): 43–44.
[32] Temkin (2003); Temkin (2014).
[33] McMahan (2002).
[34] Nagel (1989): 138–188.
[35] Cf. Galewicz (2016): 41–44; Galewicz (2017): 20–21; Nowak (2017): 80–85.
[36] Crisp (2003).
[37] Zameska (2020): 49.

> We can invest in a medicine that would enable one young person who suffers from a deadly disease to live a normal life. The other 99,999 equally young people who suffer from the same disease will die in two days. With the same amount of resources we can develop a medicine that will enable the whole group (100,000 people) one day of very pleasant life. Let us stipulate that this option yields more cross-personal aggregate utility than the utility gained by the medicine that completely cures only one person.[38]

As Zameska observes, when confronted with such a case, prioritarianism implies that we should choose to provide the whole group with one pleasant day instead of completely curing one person. This upshot is counterintuitive, especially if we realize that in the case of a larger group, we could imagine a similar story regarding one pleasant minute of life for many vs. a complete cure of a disease for one.

In his reply to Zameska's arguments, Tännsjö states that "the theory he advocates does not present us with any additional defensible position"[39] since it fails to provide reasonable conclusions in case of population ethics. Furthermore, Tännsjö points out that Zameska's view faces a problem with the exact placement of the sufficientarian threshold: "If he keeps the critical level low, very near the level where a life prudentially speaking starts to be worth living, he will have to acknowledge something very close to the repugnant conclusion."[40] However, if he moves the threshold substantially above the current limit, as Tännsjö observes, "[i]t now seems that an empty world is better than a world with a huge population living close to but under the sufficientarian level of a life that is good enough in order to count positively in the moral calculus, but considerably better than a life just worth living."[41]

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[38] Ibidem: 53.
[39] Tannsjo (2021): 67–68.
[40] Ibidem: 68.
[41] Ibidem: 69.

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