

Drinking in the last chance saloon: Luck egalitarianism, alcohol consumption, and the organ transplant waiting list

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Abstract

The scarcity of livers available for transplants forces tough choices upon us. Lives for those not receiving a transplant are likely to be short. One large group of potential recipients needs a new liver because of alcohol consumption, while others suffer for reasons unrelated to their own behaviour. Should the former group receive lower priority when scarce livers are allocated? This discussion connects with one of the most pertinent issues in contemporary political philosophy; the role of personal responsibility in distributive justice. One prominent theory of distributive justice, luck egalitarianism, assesses distributions as just if, and only if, people's relative positions reflect their exercises of responsibility. There is a principled luck egalitarian case for giving lower priority to those who are responsible for their need. Compared to the existing literature favouring such differentiation, luck egalitarianism provides a clearer rationale of fairness, acknowledges the need for individual assessments of responsibility, and requires initiatives both inside and outside of the allocation systems aimed at mitigating the influence from social circumstances. Furthermore, the concrete policies that luck egalitarians can recommend are neither too harsh on those who make imprudent choices nor excessively intrusive towards those whose exercises of responsibility are assessed.

Keywords: Distributive justice; Liver transplantation; Medical ethics; Health inequalities; Luck egalitarianism; Organ allocation; Organ shortage; Personal responsibility; Transplantation.

Introduction

Political philosophers often test the plausibility of principles by applying them to hypothetical cases. In such cases, we may deliberate over whether to change the direction of a rampant trolley towards the few innocents to save the many or who among fellow sailors in the lifeboat should be sacrificed so that others may live.¹ Fortunately, the real world rarely exposes us to dilemmas of such a stark nature, but the allocation of livers between potential transplant recipients suffering from End Stage Liver Disease (ESLD) seems one such case. Despite much effort to increase the number of available organs, the organ shortage is still a sad fact and likely to be with us for the foreseeable future. In the US, approximately 15,000 people are waiting to receive the 7,000 livers available annually for transplant (OPTN, 2015).² Because of scientific development, receiving an organ transplant is a viable solution for many that holds the promise of prolonging and improving life. Unfortunately, for all too many, the promise goes unfulfilled. People die while waiting for an organ, and this confronts us in a way much similar to the above hypothetical cases. It tasks us with answering the question: Who shall live when not all can live?

Regarding how to allocate livers between potential transplant recipients, it is a steady source of controversy that people need this procedure for vastly different reasons. The needs of a large group came about because of their own past behaviour in relation to alcohol consumption.³ Their illness is classified as Alcohol-Related End Stage Liver Disease (ARESLD) and contrasted with those who need a new liver for other reasons, such as congenital biliary atresia, congenital polycystic liver disease, and primary sclerosing cholangitis (non-ARESLD) (Glannon, 2009, p. 23). It has been argued that relevant differences between these groups justify introducing policies of *differentiation*, which gives lower priority to all or some of those with

¹ Philosophy is not for the faint-hearted, but the examples serve a purpose, and as Philippa Foot duly remarked: “The levity of the examples is not meant to offend” (Foot, 2002, p. 31)

² The singular term “one liver” is slightly misleading. The emerging procedure of using living donors opens up the possibility of several persons living with what originated as one liver (Muller et al., 2007). This intriguing development, however, is not yet able to address the shortage. The numbers presented here already take into account the existence of alternative sources supplementing the more traditional cadaveric livers.

³ Other sources of liver failure relate to behaviour as well (i.e. Hepatitis C and intravenous drug use, or paracetamol overdose). A discussion of those instances will not be undertaken here.

ARESLD compared to those with non-ARESLD. Such policies have the potential to alter the chance of getting a new liver for a large number of people. Currently, ARESLD accounts for a large proportion of performed transplants: 22.1 percent in the United States, 16.6 percent in Canada, and 19.9 percent in the United Kingdom (D. A. Stell, McAlister, & Thorburn, 2004).

This article approaches these distributive questions from the perspective of luck egalitarianism, an influential theory of distributive justice. Luck egalitarianism is a responsibility-sensitive theory that considers distributions as just if, and only if, people's relative positions reflect their exercises of responsibility (Lippert-Rasmussen, 1999). It has been suggested that luck egalitarians would favour giving lower priority to people with ARESLD (Arneson, 2004, p. 20; Fleck, 2011; Knight, 2009, p. 159; MacDougall & Trotter, 2012; Segall, 2007, p. 177, 2010, p. 29; Shiffrin, 2000; Sobel, 1999; Vincent, 2009). However, such arguments have not yet been elaborated in detail, and some luck egalitarians implicitly shy away from this conclusion (Cappelen & Norheim, 2005; Segall, 2010). This article seeks both to contribute to the specific debate on differentiation in relation to livers and the larger debate on luck egalitarianism in health. A thorough discussion of luck egalitarianism in the context of liver transplantation is able to provide new insights to the luck egalitarian literature for a number of reasons. The existing literature on luck egalitarianism in health often consists of more general discussions about the strengths and weaknesses of luck egalitarianism in health (Albertsen & Knight, 2015; Le Grand, 2013; Segall, 2007, 2010, 2013; Voigt, 2013).⁴ Taking up a specific subject such as liver allocation allows for a different discussion. It enables us to assess how responsibility-sensitive policies could be implemented, which obstacles we may face in that regard, and the extent to which we find the critiques in the general literature persuasive in this specific context. The case at hand, the allocation of livers, has some features of its own, which makes it a particularly good case to address. The shortage provides a stern test for the luck egalitarian principles as it forces us to consider whether we find them plausible when we face tough

⁴ For more specific discussions see (Albertsen, 2015c; Andersen, 2014)

choices with lives at stake. Another interesting feature is that the causality between behaviour- and ARESLD is relatively clear. We do know whether a transplant need is caused by alcohol consumption (Dietrich, 2002; The National Clinical Guideline Centre for Acute and Chronic Conditions, 2010, pp. 99–117). Although the presence of causation does not mean that people are suitably responsible for their need, a layer of complexity is removed that characterises, for example, the debate on smoking and lung cancer given that people contract lung cancer without smoking.

The article takes up these questions by, first, briefly introducing the medical aspects of liver transplantation and the existing literature on differentiation. It then presents a principled luck egalitarian case for differentiation and contrasts this with the luck egalitarian positions that implicitly reject such differentiation. Then, the article proceeds with a discussion of specific measures to make the current US system for liver allocation more responsibility sensitive, and finally, it addresses important critiques. The first critique argues that policies of differentiation would be inconsistent with well-founded practices other places in society. The second critique holds that luck egalitarian policies are too harsh towards those who are worse off through their own choices. The third critique claims that luck egalitarianism goes astray when failing to provide people with fresh starts. Finally, the fourth critique stresses that luck egalitarianism requires shameful revelations from people in order to assess responsibility. While the critiques are not new,⁵ discussing them in this specific context allows for a different assessment of their strength. It is argued that the luck egalitarian arguments and policies in the context of allocating livers are able to resist such criticism. In the concluding remarks, it is argued how the account presented here has important advantages compared to the existing literature on differentiation; most importantly, that the luck egalitarian account comes with a clear rationale for when to differentiate, supports individual assessments of responsibility, and is able to endorse initiatives aimed at mitigating the influence from luck and circumstance both outside the

⁵ These critiques are often taken as good arguments in luck egalitarianism in the context of healthcare (Bævre & Cappelen, 2015; Feiring, 2008; Hausman, 2013, pp. 100–101; Maily, 2005; Venkatapuram, 2011, p. 198)

transplant system and inside the allocation process.

Differentiation: The current debate

Recalling the Aristotelian idea of treating like cases alike and, conversely, treating unlike cases unlike (Aristotele, 1997, p. 20), any plausible argument favouring differentiation must point towards some morally significant difference between potential transplant recipients with ARESLD and those with non-ARESLD. If we consider, first, the consequences of non-treatment, the literature does not suggest that the groups are different. One study reports that without transplantation, the five-year survival rate in patients with ARESLD is 50 percent, (Trzepacz & DiMartini, 2011, p. 216), while another estimates it to be as low as 23 percent (Varma, Webb, & Mirza, 2010, p. 4377).

Consider, instead, the benefits of treatment. To suggest this as a reason for differentiation has clear historical roots. Until the 1980s, evidence suggested lower post-transplantation survival rates among those with ARESLD (Caplan, 1994, p. 220; Scharschmidt, 1984; Trzepacz & DiMartini, 2011, p. 222). Today, the survival rates between the groups are not significantly different (Anantharaju & Van Thiel, 2003; Batey, 1997; Caplan, 1994; Kumar et al., 1990; Maily, 2005).⁶ Such similarity is also found when considering broader measures of wellbeing (Burra & Lucey, 2005, p. 496). Thus, the two groups seem not to be significantly different regarding the prospects without treatment or the potential benefit from treatment. While one way of engaging in the debate would be to doubt these empirical findings, this article sets this question aside. Instead, the above similarities are taken as given. Many who are sceptical towards differentiation embrace these similarities and argue that we should reject differentiation in the absence of relevant medical differences between the two groups (Anantharaju & Van Thiel, 2003; Batey, 1997; Caplan, 1994; Kumar et al., 1990). While current practices are aligned with such views, a group of philosophers have maintained that we should introduce policies of differentiation (Glannon, 1998, p. 35, 2009, p. 24; Moss & Siegler,

⁶ Often ascribed to the introduction of immunosuppressants such as cyclosporine and tacrolimus (Starzl, 2011, p. 9)

1991, p. 1296; Veatch, 2000, p. 321). They argue that *from a fairness perspective, we should differentiate in such a way that everyone with ARESLD receives lower priority than those in the group of non-ARESLD.*⁷ This article argues that approaching the question from a luck egalitarian perspective offers important insights beyond this existing literature.

The luck egalitarian case for differentiation

A classic luck egalitarian, Cohen, argued that we should evaluate distributions according to whether they reflect choice or luck, justice disapproving of distributions reflecting the latter but not the former.⁸ In the following, luck egalitarianism will be taken as asserting that distributions are just if, and only if, people's relative positions reflect their exercises of responsibility.⁹ This section argues that the luck egalitarian view on distributive justice offers two important insights to the debate over differentiation, each of which reflects the central luck egalitarian sentiments that distributions should be allowed to reflect choices that people are responsible for, but not differential luck.

Consider the following example regarding liver allocation. Jack and James relevantly similar, they are both well educated, have similar middleclass incomes, sufficient knowledge regarding the possible adverse consequences of alcohol consumption, and no family history of or genetic disposal towards consumption of alcohol. Jack drinks to excess, while James does not – this is the only difference between them.¹⁰ Twenty years down the road, they both contract

⁷ The cited authors consider this a question of distributive justice (Brudney, 2007, p. 44; Moss & Siegler, 1991, p. 1297; Veatch, 2000, pp. 314–315). Smart agrees that it is not about punishment but rather restitution (Smart, 1994, p. 28). Compared to the other cited authors, he is, however, more focused on the moral fault of the persons involved and to some extent the moral value of their pursued activities.

⁸ See (G. A. Cohen, 1989). For other early statements of luck egalitarianism, see (Arneson, 1989; Rakowski, 1993; Roemer, 1993).

⁹ See, (Knight, 2009, p. 230; Lippert-Rasmussen, 1999, p. 479) For recent contributions to the luck egalitarian literature, see (Albertsen & Midtgaard, 2014; Arneson, 2004, 2011; Eyal, 2006; Knight, 2009, 2013a, 2013b, 2015; Lazenby, 2009; Lippert-Rasmussen, 2011, 2015; Sandbu, 2004; Segall, 2011, 2013; Stemplowska, 2009, 2011, 2013; Tan, 2012).

¹⁰ The characteristics mentioned here are not meant as a specification of a theory of responsibility, that is, they are not mentioned because they are believed to form a complete list of factors which may be considered as removing a person's responsibility for a health need had James and Jack been different on any of the parameters. They are mentioned merely to give an impression of what is meant when these two person are said to be relevantly similar.

ESLD. Jack suffers from ARESLD, while James' need for a new liver is unrelated to alcohol. For luck egalitarians, the fact that Jack's predicament can be ascribed to his past voluntary conduct (whereas James' cannot) is one important factor in deciding to whom a benefit should go. All else being equal, fairness tells us that it is more important to help James. This does not mean that Jack has no claim to help but, rather, that his past choices weakens this claim. Thus, if a suitable liver becomes available for transplant, luck egalitarians would consider it just to give priority to James. This principled claim means that, all else being equal, we would have luck egalitarian reasons to favour policies of differentiation in this case. When tasked with distributing the scarce resources of the world, it matters morally if some are responsible for their plight while others are not. On the luck egalitarian account, we would maintain that this results in a weakened claim to such resources, giving priority, instead, to those who have not in such a way contributed to their own need; those whose needs reflect their bad luck. Faced with two groups, between which the only difference is that in one group, the persons are responsible for their transplant needs, luck egalitarians must hold the view that we have fairness reasons to give priority to the group with non-ARESLD. In a situation where all in one group is responsible for their transplant need, we should, all else being equal, ensure that those in a group where none is in that way responsible receives a liver first.

However, this does not exhaust the luck egalitarian contribution. The above example serves to illustrate another luck egalitarian commitment. Note how the two-person case was presented with all else being equal, explicitly pointing out how a range of important social and natural circumstances were similar across Jack and James. This reflects how luck egalitarians consider as unjust distributions where people are differentially affected by their social or natural circumstances. The luck egalitarian commitment to let distributions reflect people's exercises of responsibility also includes, conversely, that distributions should not reflect differential luck. The commitment that people should not fare worse because of bad luck is integral to the luck egalitarian view. The focus on people's choices and personal responsibility presented above is thus complemented by a strong resistance towards distributions of

transplant needs heavily influenced by people's circumstances. This lends weight to the idea already presented of treating those who are not responsible first but also supports initiatives aimed at eliminating such differential luck. The possible content of such initiatives will be addressed more thoroughly later.

Any attempt to introduce policies reflecting luck egalitarianism faces two important obstacles. These were fittingly identified by Cohen, who acknowledged the following: 'It can be bad policy to seek to promote justice, whether because that would in fact not promote justice or because seeking to promote it would prejudice other values' (G. A. Cohen, 2008, p. 381). The quote nicely sums up the two different obstacles relevant in this context. The first covers instances where introducing seemingly responsibility-sensitive policies ends up disadvantaging people who are in fact not responsible for their need. The second covers instances where other values or concerns make it so that we should not, all things considered, introduce luck egalitarian policies. As most luck egalitarians are pluralists believing we should cater for other concerns along with distributive justice, both these obstacles are relevant for our discussion (Arneson, 1989, p. 81; G. A. Cohen, 1989, p. 906; Knight, 2009, p. 232; Rakowski, 1993, p. 74; Tan, 2012, pp. 22, 31; Temkin, 2003, p. 769). When discussing luck egalitarianism in health, we can thus distinguish between two reasons for not introducing responsibility-sensitive policies of differentiation. One is that it turns out that the group under discussion (or some members of it) are not responsible for their health deficit. The other is that even though they are responsible, we have other, pluralist reasons for not introducing such policies. Pluralism here would mean that we should not abandon concerns for efficiency, beneficence, and urgency but consider them alongside the luck egalitarian vision of distributive justice.

As mentioned earlier, it is commonly asserted in the luck egalitarian literature that there is at least a principled luck egalitarian case for differentiation. The above discussion affirms that this is the case. However, when we examine what prominent luck egalitarians write in the context of health, they seemingly shy away from embracing policies of differentiation. One often suggested policy, which is seemingly responsibility sensitive, introduces a tax on unhealthy

behaviour (Cappelen & Norheim, 2005, 2006; Le Grand, 2013). The general thought is that such a tax could be used to fund the expenses created when those behaviours turn into a medical need. Such proposals for institutional reactions to people's responsibility for their own health are often suggested because they seem more attractive than denying treatment. Norheim and Cappelen suggest it as the solution when risky behaviour leads to diseases that are costly compared to their income, life threatening, or undermine political capabilities (Cappelen & Norheim, 2005, 2006). While much could be said for such policies in other contexts, they seem of little use here. The shortage is not (only of) monetary nature; the scarcity is of organs as such.

In his important work on distributive justice and health, Segall argues that apart from our luck egalitarian concerns regarding distributive justice, we should also have other concerns, such as those of fulfilling people's basic needs (Segall, 2010, p. 69). In cases of choosing between people whose basic needs are unfulfilled, Segall proposes a weighted lottery in favour of the person not responsible for the need.¹¹ Even if Segall does not specify what he means by basic needs going unfulfilled, people needing a new liver must clearly qualify as having an unfulfilled basic need. Implementing such a system here would effectively mean that sometimes those who are responsible for their behaviour will be treated on equal terms with those who are not. It seems unfair to do so and goes against the principled luck egalitarian case presented above.

This section has argued that there is a principled luck egalitarian case for differentiation and pointed out that luck egalitarianism can incorporate a plural concern for other measures in deliberating over whether to introduce responsibility-sensitive policies. When examining the concrete measures endorsed by present applications of luck egalitarians to health, such as a weighted lottery or taxes on unhealthy behaviour, they seem not quite to express our luck egalitarian concerns. Luck egalitarianism is compatible with many views on what it means to be responsible¹² and with different institutional responses to the presence of responsibility. On the

¹¹ For an interesting critique of this solution, see (Nielsen & Axelsen, 2012, p. 312). In his reply to Nielsen and Axelsen, Segall expresses doubts regarding the weighted lottery (Segall, 2012, p. 327).

¹² Removed to make review anonymous.

latter, it seems that in a context of acute scarcity, luck egalitarians must address the reduction of access to treatment for those who are responsible.

Luck egalitarianism, distributions of livers, and the real world

So far, a principled argument for giving priority to a person who has not brought about his need for a new liver has been presented. It was argued that as a matter of distributive justice, we have reasons of fairness to favour such policies of differentiation. Even those convinced by the principled argument could submit that the real world is never like the stylised example of Jack and James, and for that reason, we would be ill served if we took our principled convictions to the transplant clinics. The quote from Cohen provided a way of understanding this worry; one connected to factors mitigating responsibility, the other to the problem introducing luck egalitarianism alongside other values. Below, a minimal account of responsibility is given in which empirical factors are highlighted that any attempt to implement the luck egalitarian principles should take into account.

Assessing responsibility

The principled argument presented above claimed that if people are responsible, we have luck egalitarian reasons of distributive justice to give them lower priority. This claim is importantly different from describing what it means to be responsible for acquiring ARESLD and from the empirical assessment of how many people are actually so.¹³ While the latter is a complicated empirical question, something must be said about which factors and concerns would arguably feature prominently in such assessments. This section reviews some factors which the empirical literature gives us reason to examine, however this is done without specifying an actual theory of responsibility. It would be too simplistic to suggest that it is both a necessary and a sufficient

¹³ It is sometimes argued that luck egalitarianism provides sound conclusions even if we are never responsible for our relative positions (Knight, 2006).

condition that a person's past choice(s) brought the need for a liver about.¹⁴ As a clear illustration of why this is the case, consider a mentally handicapped person who is residing in an asylum where he will only be given food if he drinks large amounts of alcohol every day. Clearly any transplant need arising from his choices in this bizarre arrangement would not qualify as something for which the person is suitably responsible even though ordinary language permits us to say that he did chose to drink the alcohol. The example purposely points towards a number of important considerations regarding potential factors mitigating responsibility. For any way a person could cause his or her own transplant need,¹⁵ a number of other factors would surely have to be taken into account. The empirical literature can inspire though not settle this discussion. Consider, first, *external factors* such as direct threats or social circumstances, that influence people's behaviour in relation to alcohol consumption (Glannon, 1998; Walker, 2010). There is quite a lot of evidence that social factors such as alcohol abuse in the family counts as risk factors towards alcohol abuse (Ellis, Zucker, & Fitzgerald, 1997; Rhee et al., 2003), but also *internal factors* can matter (Glannon, 1998; Walker, 2010). Genetic factors are suggested as affecting vulnerability to alcohol and propensity for becoming addicted (Buscemi & Turchi, 2011; Ducci & Goldman, 2008). An *epistemic factor* should also be taken into account. Is the knowledge regarding the adverse effects of alcohol attainable or comprehensible to the person in question? This seems especially interesting since knowledge/competence mediates or lessens the effect of other known risk factors for alcohol consumption (Stenbacka & Leifman, 2001). Such thoughts, as Goodin's discussion of smoking reminds us, should also include whether cognitive errors make us vulnerable to committing mistakes that we are in general prone to making when evaluating risks (Goodin, 1989, pp. 21–22). Interestingly, studies show that those consuming alcohol are very much aware of its link with liver disease; in fact

¹⁴ Following Hart, we could also call this causal responsibility (Hart, 1968, pp. 214–215). A number of authors have suggested that for a person to be causally responsible for a given state of affairs, a number of further conditions must be fulfilled (Dworkin, 1981, p. 27; Glannon, 1998, p. 33), but here, it is not necessary to take a stand on the correct interpretation of causal responsibility.

¹⁵ Consider: the consumption of alcohol; initiating alcohol consumption that turned into an addiction; not seeking help when addicted; not following advice given; not administering the necessary immunosuppressant drugs after receiving an initial transplant (creating a new need for a transplant).

even more so, than those without the behaviour.¹⁶ An interesting further aspect of this discussion is a knowledge requirement. While the risk of creating a need has already been discussed, it is interesting to consider whether people also need to know about the scarcity of livers and that they will be given less priority, should the need arise. Glannon suggests something like this (Glannon, 1998, p. 34), but luck egalitarians would probably maintain that while fair warnings about the possibility of being given lower priority can be a good policy for reasons of incentives, it should not be required in order to assess responsibility. People could still be responsible for creating their own need and be disadvantaged fairly as a consequence of that, even when they did not know (and had not been told) that they would be given lower priority.

A final remark should be made regarding addiction. It is sometimes presented as if alcoholism as a disease where people are addicted¹⁷ to substance abuse rules out the possibility of personal responsibility. Looking into whether people are addicted requires some theory of addiction, but this will not be presented here. However, it might be sensible to state that such a theory does not necessarily require that people are completely unable to alter their ways but, rather, that it would be unbearably hard for them to do so (Goodin, 1989, p. 25). Addiction does not rule out that one could be considered responsible for initiating the abuse leading to said addiction or responsible for whether or not one seeks counselling.¹⁸ The above remarks on internal, external, and epistemic factors are not meant as an exhaustive list of how to assess responsibility. It does, however, present a number of relevant factors that should clearly be taken into account if and when one examines the extent to which a person or a group of patients is responsible for such needs. In relation to discussions of luck egalitarianism, we can find many different theories of responsibility, some of which would presumably include other elements than the above minimal

¹⁶ (Blaxter, 1990, p. 157). Note, however, that people have a tendency to use more complex causal explanations when they or their loved ones become sick (Bailey, Montgomery, & McMillan Boyles, 2009; Blaxter, 1990, p. 157).

¹⁷ For an interesting piece on addiction, see (L. K. Stell, 2002).

¹⁸ It should be noted that some suggest that different factors matter regarding initiation and becoming addicted (Kalaydjian et al., 2009).

account. This includes the idea that we could only hold people responsible for what we could reasonably expect them to avoid (Segall, 2010, 2012; Vallentyne, 2008), Roemer's idea that society at large decides which factors people are responsible for (Roemer, 1993, 1995, 2003), and Knight's suggestion that committees of experts could settle such questions (Knight, 2006, 2009). We do not need to go deeper into different approaches to responsibility for the purpose here. The next section discusses the implementation of luck egalitarian (or responsibility-sensitive) policies, thus asking the question of what to do if some are indeed responsible for their need for a new liver.

Luck egalitarianism and the current US allocation system

What would a luck egalitarian policies look like? To illustrate this, consider the US system for allocating livers. Today, three factors are vastly important for determining who should have the available livers. The first is whether a person is classified as a Status 1 patient, which includes 1A candidates (life expectancy of hours to a few days) and 1B (patients under 18).¹⁹ The second factor is geography. Here, the main distinction is between the local level, referring to areas designated to local Organ Procurement Organizations (OPO), and the regional level, referring to the 11 geographical transplant regions, each covering several OPO's. The third factor is the objective, numerical MELD score.²⁰ It assigns transplant candidates aged 12 and older a score which can be used to predict the likelihood that they will survive the next three months (Burra & Lucey, 2005, p. 493; P. Kamath, 2001; P. S. Kamath & Kim, 2007; Kim & Lee,

¹⁹ Interestingly, this priority given to young people could also be interpreted as adhering to luck egalitarian values since it would seem that young people are never responsible for their liver failure.

²⁰ When dealing with children under the age of 12, a different measure referred to as the PELD score is used.

2013). MELD ranges from six (less ill) to 40 (gravely ill) and is calculated²¹ using routine lab test results (United Network for Organ Sharing (UNOS), 2011).²²

To illustrate how the system works, consider a population admitted to the waiting list, all being similar in relevant aspects, such as blood type. Among these, donated livers are allocated, first, to the persons in the highest category. The distribution continues downwards until either no more patients remain on the list or, as is usually the case, no more livers are available for distribution.²³

1: Regional level:²⁴ Status 1 patients in descending point order²⁵

2: Local and regional Candidates with MELD Scores ≥ 35 in descending order of mortality, with local candidates prioritized over regional candidates at each level of MELD score

3. Local Candidates with MELD Scores $\geq 29-34$ in descending order of mortality

4. Nationwide: Candidates with Liver-Intestine²⁶ in descending order of status and mortality risk scores

5. Local candidates with MELD Scores $\geq 15-28$ in descending order of mortality risk scores

6. Regional candidates with MELD Scores $\geq 15-34$ in descending order of mortality risk scores

7. Nationwide Status 1A candidates in descending point order

²¹ The actual calculation is carried out using this formula: MELD Score = $(0.957 * \ln(\text{Serum Cr}) + 0.378 * \ln(\text{Serum Bilirubin}) + 1.120 * \ln(\text{INR}) + 0.643) * 10$.

²² These include Bilirubin measuring how effectively the liver excretes bile; INR (prothrombin time) measuring the liver's ability to make blood clotting factors, and Creatinine measuring the kidney function (often associated with severe liver disease).

²³ Based on the newly approved (though not yet implemented) adult donor liver allocation algorithm (OPTN, 2012).

²⁴ The terms 'local' and 'regional' refer to the geographic location of the organ donor.

²⁵ Here, the term 'points' does not refer to MELD but a distinct scheme awarding different points depending on the nature of the condition.

²⁶ This new addition covers people with short bowel syndrome developing ESLD.

8. Nationwide Status 1B candidates in descending point order
9. Nationwide Candidates with MELD Scores ≥ 15 in descending order of mortality risk scores
10. Local Candidates with MELD Scores < 15 in descending order of mortality risk scores
11. Regional Candidates with MELD Scores < 15 in descending order of mortality risk scores
12. All other Candidates with MELD Scores < 15 in descending order of mortality risk scores.

Which responsibility-sensitive measures could be introduced in this context? The first proposal, also proposed by Veatch and Glannon) amounts to deducting one or two points from the MELD score for patients with ARESLD (Glannon, 1998; Veatch, 2007). Even though its proponents articulate it as giving a lower MELD score, it is perhaps better understood as introducing a responsibility-adjusted MELD score. It would be a simple task to implement it in the system presented above, and such a change would amount to a deduction in an influential parameter. This way of introducing luck egalitarian concerns amounts to reducing the chance of receiving a liver for those deemed responsible. Another suggestion would be to let responsibility play a part, not as an adjustment to the MELD score but as an independent factor along with geography, age, and MELD. Consider how geography as an independent factor gives higher priority to those in the proximity of the available liver. In a similar fashion, a responsibility factor could be introduced, lowering those responsible for their ARESLD to a subsequent point on the list. Theoretically, this differs from the solution above since it would mean that responsibility is not limited to influencing the allocation of livers only where MELD is taken into consideration. To illustrate: The responsibility-adjusted MELD score is capable of rearranging people within each category and, depending on the deducted amount, in some cases move a patient down to a lower category.²⁷ The second solution, according to which responsibility is a separate factor, allows for more of such movement. For example, level two in the ranking above

²⁷ Depending on the precise amount deducted from the MELD score, it would be possible to move local candidates from position 2 to 3, 3 to 5, 5 to 9, and 9 to 10. For regional candidates, the possible movements would be from 2 to 6 and from 6 to 10.

(currently relating to geography) could be changed so that it gave priority to responsibility instead of giving preference to local over regional patients in the filtering of possible transplant recipients. Similar adjustments are possible in subsequent steps on the list.

For both the above suggestions, an interesting specification remains; that is, whether they should be implemented for everyone or only some with ARESLD. Proponents of differentiation such as Veatch, Glannon, Moss, and Siegler seem to suggest that differentiation for everyone with ARESLD is the correct policy. This gives rise to the concern that if not all in that group are sufficiently responsible for their condition, they will be unfairly disadvantaged. Such a concern is often raised by those who are critical of differentiation (Balint, 2007; Beresford, 2001, p. 177; C. Cohen & Benjamin, 1991, p. 1300; Ho, 2008, p. 81; Shelton & Balint, 1997, p. 98). This implies that differentiating between the groups risks holding some responsible for a condition that reflects their social circumstances and/or genetic dispositions (Mailly, 2005; Shelton & Balint, 1997, p. 95). Luck egalitarians can favour such general differentiation based on the idea of probability. When considering the two groups, all those with non-ARESLD are not responsible for their disease, whereas, among those with ARESLD, some are responsible for it, and some are not (because of genetic predisposition to alcoholism, social circumstances in childhood, adult life, etc.). If a person is chosen at random from the first group, they are definitely non-responsible, whereas someone from the second group may or may not be responsible. This difference in probabilities may be sufficient to justify differential treatment. This is the case because everyone with non-ARESLD is worse off through no fault or choice of their own, whereas someone with ARESLD may or may not be.²⁸ The above holds under the assumption that some, but not all in the ARESLD group are responsible for their plight.²⁹ But as luck egalitarians would prefer to minimize the number of instances where someone with

²⁸ Luck egalitarians often do not discuss such issues of uncertainty, this large issue will not be discussed here. The formulation above was suggested by Carl Knight.

²⁹ Under the assumption that no one is responsible for their transplant need, luck egalitarians would not favour differentiation. It should also be noted that the smaller the proportion which are responsible the larger the likelihood that we for all things considered reasons would not introduce measures of differentiation. A point also pointed out in (Albertsen & Knight, 2015)

ARESLD who is not responsible for this condition are disadvantaged compared to the non-ARESLD group, it seems most plausible to introduce measures to assess responsibility. The problems this brings will be addressed in the next section, where three critiques are addressed. However, introducing individual assessment of responsibility seems most adequately to reflect both the many responsibility-mitigating factors mentioned earlier and the luck egalitarian concern for the non-responsible.

While the suggestion in the luck egalitarian literature is often that the luck egalitarian contribution is limited to the endorsement of differentiation, there is another possible contribution. A commitment to luck egalitarianism leads us to reconsider the weight given to other factors in the allocation process. The reason for doing so is not a rejection of pluralism but rather that luck egalitarianism might provide reasons to consider a factor to be unjustly influencing the distribution of livers in a way not sufficiently grounded in values such as efficiency and urgency. Thus, those of luck egalitarian persuasion would also want to reconsider the role of geography in the US system for distributing donated livers. Since the place of residence is arguably arbitrary, luck egalitarians could be critical of the huge importance given to geographical proximity. This is at least the case if this consideration cannot be justified by efficiency reasons. The above discusses a number of ways in which luck egalitarians could recommend changes within the process for allocating livers under the assumption that some but not all who need a new liver are responsible for their need.

These recommendations regarding the distributions of livers reflect the basic intuitions of the luck egalitarian theory, when taken alongside other concerns. However, as the section on assessing responsibility showed, it would also be a luck egalitarian concern if the distribution of transplant needs reflected luck, understood, for example, as people's social circumstances. From such a concern, another luck egalitarian contribution can be developed; one that addresses not the mechanism for allocating livers but rather the society at large. A commitment to luck egalitarianism in health would also include views within a wider area of health policies. Considering, first, the luck egalitarian resistance towards un-chosen factors affecting people's

relative positions, we could recommend a number of policies designed to mitigate or eliminate the social determinants of health,³⁰ including, but not limited to, policies of wealth redistribution, policies affecting the availability of alternatives to alcohol, or policies affecting the availability of alcohol to young people or the general population. Depending on the concrete context, a wide variety of such policies could be employed to directly or indirectly reduce the influence of social circumstances on the distribution of transplant needs. The above suggestions reflect the two sides of luck egalitarianism. They express the general thought that responsibility sensitivity implies both that we should let people fare in accordance with their exercises of responsibility but also that we should eliminate circumstances unequally effecting how people fare.

Having considered these suggestions, it might be interesting to reflect upon whether and to what extent they differ from the existing philosophical contributions favouring differentiation. The luck egalitarian commitment to mitigate the influence of circumstance is pursued both inside and outside the allocation system. Outside this allocation process, it can endorse policy measures to mitigate the extent to which people's need for a transplant is contingent on their social circumstances. Within the allocation process, it sets itself against the arbitrary influence from geography in allocation decisions. Furthermore, it allows for responsibility-sensitive policies, but offers those who are not responsible for their alcohol consumption the opportunity to be treated on equal terms with others based on an individual assessment. All these elements are interesting improvements compared to the existing literature favouring differentiation. In this, little attention is paid to policies affecting society at large and the distribution of needs flowing from social circumstances, and there also seem to be too little room for individual assessment. We now turn to a number of prominent critiques of differentiation, evaluating their strength in this context.

³⁰ For a discussion of this commitment in relation to social determinants, see (Albertsen, 2015b). For an interesting argument regarding luck egalitarianism and prevention, see (Couto, 2015).

Assessing critiques

In this final section, a number of relevant critiques will be considered. While some of the critiques are also discussed elsewhere in the literature on luck egalitarianism and health, discussing them in this context is quite interesting because of the acute shortage and dire consequences for those untreated. The first critique, prominent in the general discussion over differentiation policies towards people with ARESLD, suggests that introducing such policies is inconsistent with practices elsewhere. Three further critiques will be addressed. The first holds that luck egalitarianism is too harsh on those whose disadvantage reflects their own choices, while the next argues that luck egalitarianism fails to provide people with fresh starts. The final critique discussed submits that assessing responsibility requires shameful revelations from people. All these critiques are often considered as good reasons not to introduce luck egalitarian measures in the context of health.

Would luck egalitarian policies of differentiation be inconsistent because society does not in general give lower priority to health needs arising from risky behaviour (Balint, 2007, p. 5; Beresford, 2001, p. 178; Caplan, 1994, p. 220; C. Cohen & Benjamin, 1991; Ho, 2008, p. 81; Shelton & Balint, 1997, p. 98)? This critique is labelled the *inconsistency critique*. In effect, the critique draws on current practices in other spheres of society, inferring that they provide us with good reasons for rejecting arguments for differentiating (luck egalitarian or otherwise). As an illustration of such reasoning, consider Caplan, who writes that if we favour lower priority to those with ARESLD,

equity would require exclusionary policies for individuals who require medical care as a result of conduct as diverse as participation in athletics, horseback riding, failure to wear a seatbelt or helmet while operating a motor vehicle, failure to obey speed limits, failure to stop smoking, the ownership and use of a firearm, morbid obesity, employment in environments that are dangerous or stressful or, owning a large dog, a chain saw, or a swimming pool. (Caplan, 1994, p. 220)

Thus, Caplan effectively questions whether those favouring exclusionary policies in the case of liver allocation would consistently apply those principles in other areas where risky or unhealthy behaviour can result in low levels of health. Luck egalitarians must clearly be committed to the view that those who are responsible for their own low level of health should be given lower priority. However, accepting this distributive ideal, and favouring it in the case of livers, is not the same as a commitment to introduce choice-sensitive policies across the board. As already stressed, policies of differentiation would only be adequately called for when people are in fact responsible (however construed), and when countervailing considerations of values other than distributive justice do not rule out the introduction of such policies. Whether or not this would be the case in the mentioned areas requires careful assessment rather than sweeping statements. Caplan is right, however, that luck egalitarians must, in principle, be open to the possibility that other areas also require policies of differentiation. Importantly, however, Caplan is wrong regarding what consistency would require in that regard. Unlike what Caplan suggests, lower priority is not the same as exclusion. While critiques of luck egalitarianism all too often presuppose that those who are responsible for their own disadvantages should be denied treatment, there is a wide variety of ways in which people could be held responsible, the proper egalitarian response varying between different kinds of disadvantages. Regarding the distribution of livers, it has been argued that a policy which removes or significantly dampens a person's chance of receiving treatment may be justified. However, in other areas, lower priority does not necessarily mean denial of treatment, because in those areas, we are not facing an acute shortage. Perhaps it would instead involve co-payments for treatment, higher insurance premiums, longer waiting time, or a tax on specific unhealthy activities. Which of these luck egalitarian policies would be most relevant for a given area depends on the finer characteristics there. Thus, luck egalitarianism is not inconsistent in the way Caplan suggests and provides principled answers regarding where and to what extent we should introduce measures aimed at differentiating in other areas of health.³¹

³¹ Some favouring differentiation argues for such a difference. Moss and Siegler highlight the acute scarcity

The next critique is sometimes referred to as *the harshness objection*.³² It holds that luck egalitarianism is too harsh on those who are responsible for their plight. This is considered an important critique, also among those sympathetic to luck egalitarianism.³³ The example often deployed in the literature is that of the uninsured motorcyclist who crashes without a helmet and, thus, should be left untreated at the roadside. One immediate reaction from luck egalitarians would be to point out that being left to die is but one of several possible consequences.³⁴ Another possible consequence would be to let those who brought their medical need upon themselves pay for treatment. Whatever the viability of such a strategy in other contexts, the organ shortage makes it futile in the liver allocation case. Given the scarcity of organs, we cannot treat everyone and charge those who are responsible for their condition. Since the stakes are so high that some will be denied the only viable treatment, perhaps the allocation of livers is especially suited for discussing the harshness objection. Here, there is no room for middle-ground solutions such as user payment or ex-ante taxation. In the end, someone is not receiving a liver, and the luck egalitarian policies make it more likely that this will happen to those who brought the transplant need upon themselves. However, the exact same serious consequences which make it so apt to raise Anderson's critique in the context of liver allocation at the same time reduce its strength considerably. The pull and persuasiveness in the roadside case is that society could easily, and perhaps without great cost, help this person. The cost of saving him is diffuse, while the consequences of doing nothing are both concentrated and vivid. Luck egalitarians refusing help can come across as heartless and perhaps even as penny pinching if and when the reason is that the costs should not be passed on to others. In the case of allocating livers, consequences are tough, and as long as shortage is among us, allocating a liver to one person is likely to mean very tough consequences for

and (what they consider to be) the straightforward causality (Moss & Siegler, 1991, p. 195), while Smart stresses that the activity of drinking alcohol has little value to society (Smart, 1994).

³² For a discussion of this, see (Anderson, 1999; Fleurbaey, 1995; Knight, 2005, 2015; Voigt, 2007).

³³ Among those are (Arneson, 2000; Segall, 2007). Not all luck egalitarians consider the consequences obviously unfair (Stemplowska, 2009, p. 252).

³⁴ See (Knight, 2009, p. 141). See also Olsaretti's idea of stakes (Olsaretti, 2009, 2013).

another. The harshness here stems from the shortage rather than luck egalitarian policies. 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 egalitarians recommend seem not overly harsh and not anywhere near as implausible as Anderson depicts them. We must make a tough choice; everyone's needs are taken into account, but they are so along with questions of responsibility.

Recently, an interesting concern has been raised regarding luck egalitarianism; namely, that luck egalitarianism fails in providing a 'fresh start' to those who fare badly. The critique was developed by Fleurbaey (Fleurbaey, 2008) and has recently been explicitly applied to the context of health (Vansteenkiste, Devooght, & Schokkaert, 2014).³⁵ Could we say that the luck egalitarian allocation of livers goes astray in light of this critique? Are we in an important way denying those who are responsible for their own need a deserved fresh start in life? The reply to such a concern seems much in line with the one given to the harshness objection. Whatever the intuitive pull giving people a fresh start may have in a situation in which these can be provided easily and at manageable costs, this is not the situation that confronts us here. The number of fresh starts that we are able to provide depends on the number of livers available, and providing a fresh start to some means denying it to others regardless of which principle the fresh starts are distributed by. Thus, the fresh start critique offers a reason to treat people equally no matter how they have exercised their responsibility; namely, that everyone deserves a fresh start. However, the extent to which that is a plausible position seems to rest on much of the same as the general debate over luck egalitarianism in health. Those who already have responsibility-sensitive inclinations would hardly be moved to hold a different view because a principle is put forward that seemingly implies that the past would never matter, even when considering those whose second liver succumbs to their alcohol consumption. At least when we cannot provide

³⁵ For a critique of this position see (Albertsen, 2015a)

fresh starts to everyone; luck egalitarians offer one account of how responsibility may play a role in who receives them.

The next critique to be considered is related to the process of assessing responsibility rather than the consequences that follow. It was argued earlier that when not all in the ARESLD group are responsible for their condition, luck egalitarians should prefer a system that relies on individual assessments of responsibility. The advantage of such an individual assessment is that it would allow someone in the ARESLD group to count as not responsible for his own condition. This caters for the concern examined earlier that some patients with ARESLD are for some reason beyond any doubt not responsible for their consumption of alcohol. In this way, the individual assessment reflects the genuine luck egalitarian concern for influence from circumstances. However, this modification might turn out to be a catch-22 since people who 'prove' that they are without responsibility for their past consumption of alcohol are not very likely to be fit recipients of donated livers, at least not if this also suggests that they will continue drinking after receiving the transplant. Denying liver transplants on such grounds would be a regrettable and unjust state of affairs but, nevertheless, one that also luck egalitarians, all things considered, can recommend because of efficiency considerations.

However, apart from this worry relating to the consequences of what we may find, the individual assessment of responsibility can in itself provide cause for concern. At the very heart of the advantage that individual assessment provides lures also a significant worry. The assessment has the purpose of determining whether some in the ARESLD group are not responsible for their condition. Jonathan Wolff forcefully argued what could be considered wrong with such a process (Wolff, 1998, 2010). He stresses how the process of assessing whether people are in fact responsible for their plight involves a demeaning process that lacks the appropriate levels of respect. An individual trying to establish that he is not responsible for his past alcohol consumption might have to reveal things about his past which it is for that person very shameful to reveal. Details necessary in this context could be social circumstances in youth, failed attempts to stay away from alcohol, and personal defeats in love or career

leading to alcohol consumption. The critique then is that it is shameful and humiliating to have to put forth these things in order to be able to receive a liver transplant. Two strategies have been proposed in the luck egalitarian literature as a response to this. One evokes the already mentioned pluralism of luck egalitarianism and submits that if the disadvantage associated with introducing such policies were prohibitively large, we should not introduce individual assessment (Knight, 2009). Evaluating how it would be to undergo such an assessment is somewhat speculative, but in doing so, we should note some specific features of the current allocation process. We know that for reasons of efficiency, we have good reasons to assess (and include in our allocation decisions) many things that could be considered of a personal character and perhaps also shameful to reveal. Today, psychosocial screening is common in many transplant centres in the US. The purpose of those is to give a clear picture of the potential transplant recipient. The assessment plays a part in whether a person can be admitted to a waiting list. This includes elements such as the likelihood of compliance with instructions, the presence of psychopathological issues, and whether friends and family are likely to provide a supporting environment after the transplant (Levenson & Olbrisch, 2011). Such questions are personal, but they are none the less part of the current system for efficiency reasons. If we are, for efficiency reasons, allowed to investigate all such factors, why should we not, for reasons of fairness, be allowed to inquire into people's past actions and circumstances? One might argue that existing practices also involve shameful revelations, so that nothing is gained by pointing out similarity with those. However, drawing on a recent article by Firth, we could suggest that at least in one respect, it is worse to be asked about such details for efficiency reasons rather than for reasons of fairness. In the latter context, everyone involved agrees that we are looking for factors that the person is not responsible for. According to Firth, shame as an emotion is tied to that which we are indeed responsible for. Thus, the factors that we are deemed not responsible for are not shameful to reveal (Firth, 2013). It may be that Firth's view on shame does not adequately reflect how that is commonly interpreted,³⁶ but she offers an important point

³⁶ At least ordinary usage of the term allows us to feel shameful about having a relative who is an alcoholic,

regarding why we may be more satisfied with luck egalitarian assessments of responsibility than the existing assessments made for efficiency reasons. In light of these concerns, the shameful revelations do not seem as much of an obstacle for the luck egalitarian policies. Furthermore, it is something that could be incorporated into existing practices. With these considerations, it can be concluded that the weight of the critiques regarding harshness, fresh starts, and intrusiveness should not lead us to abandon responsibility-sensitive policies, under the assumption that some are in fact responsible for their condition.

Conclusion

The above has applied the distributive theory of luck egalitarianism to the allocation of livers for transplant. It thus continues recent attempts to apply luck egalitarianism to real-world distributive decisions related to health and health care. Two distinct contributions arise from the above. One concerns luck egalitarianism in health, and the other acquires to the existing debate over differentiation. Considering the latter, while many of the existing contributions talk of fairness, luck egalitarianism provides a clearer conception of what fairness means. This provides a more solid ground for putting forward the idea of differentiation. The second contribution is that the luck egalitarian approach clearly allows for individual assessment of responsibility. The third is that the luck egalitarian principles provide us with reasons to mitigate the influences from circumstances inside and outside of the allocation process. The same principle of fairness that can endorse giving lower priority to those who are responsible for their ARESLD can endorse measures to mitigate the extent to which un-chosen circumstances, such as much poverty, affect the distribution of transplant needs outside the transplant systems and the arbitrary factors, such as geography, inside it.

The above also contributes to the effort of applying luck egalitarianism in the context of health and healthcare. The topic concerns the extreme scarcity of organs available for without implying that we are responsible for his or her alcohol consumption.

transplants and the very severe consequences for those who are not benefitted. Discussing luck egalitarianism in this context sheds light on at least three important issues. First, while luck egalitarianism might be compatible with a wide range of institutional responses to the presence of responsibility, it seems unlikely that the same institutional response would be correct in each context. As illustrated by the approaches implementing luck egalitarianism through levying taxes on unhealthy behaviour, this is seemingly not a plausible approach in a context where the scarcity of organs cannot straightforwardly be offset through such measures. The second contribution is that scarcity seemingly does not suspend our luck egalitarian principles. They seem applicable also in this situation of scarcity. The third contribution to the luck egalitarian literature is that prevalent critiques of luck egalitarianism in health seemed not to be that worrying when discussed in this context. Thus, while existing luck egalitarian approaches shy away from this, the luck egalitarian position is able to present a compelling case, even in the face of scarcity.

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