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**Ageing and terminal illness: Problems for Rawlsian justice**

**Ben Davies**

**Abstract** *This paper considers attempts to include the issues of ageing and ill health in a Rawlsian framework. It first considers Norman Daniels’ Prudential Lifespan Account, which reduces intergenerational questions to issues of intrapersonal prudence from behind a Rawslian veil of ignorance. This approach faces several problems of idealisation, including those raised by Hugh Lazenby, because it must assume that everyone will live to the same age, undermining its status as a prudential calculation. I then assess Lazenby’s account, which applies Rawls’ general theory of justice more directly to healthcare. Lazenby suggests that we should apply Rawls’ difference principle – which claims that any inequalities in social goods must benefit the worst off – to conclude that we should significantly prioritise treatment of young patients. I argue first that the existence of young terminally ill patients undermines a number of Rawlsian arguments for the difference principle. I then argue that the structure of ageing undermines the Rawlsian decision mechanism of the ‘veil of ignorance’ on which Lazenby relies. I conclude that age and terminal illness present significant problems for any comprehensive Rawlsian account of justice.*

**1. Introduction**

John Rawls’ theory of justice1 intentionally abstracts from two factors that have significant influence on individual needs: extreme illness, and old age. This paper considers Hugh Lazenby’s2 critique of the most comprehensive extension of Rawlsian theory into these areas: Norman Daniels’ ‘Prudential Lifespan Account’ (PLA).3 It then addresses Lazenby’s more direct application of Rawlsian principles to healthcare.4 Lazenby’s proposal faces significant problems, highlighting broader issues for the Rawlsian picture. Rawls’ difference principle, which demands that all inequalities benefit the worst off, is ill-suited to deal with debilitating terminal illness. Rawlsians also face problems incorporating ageing into the decision mechanism of the ‘veil of ignorance’, where individuals decide how to structure society without knowing morally arbitrary facts about themselves.

Section 2 outlines Daniels’ account and Lazenby’s criticism, along with additional concerns. Section 3 considers the implications for the difference principle of acknowledging young, terminally ill patients as the worst off in society. Section 4 outlines how the structure of ageing threatens the original position; Section 5 critically considers a response to these worries. I conclude that terminal illness and ageing cause significant problems for these two important aspects of Rawlsian theory.

**2. The Prudential Lifespan Account**

Daniels suggests that disparities between people in different age groups differ from other inequalities because most of us will occupy multiple age-groups across our lifetimes. He thus reconceives the problem of competition between age-groups as an intrapersonal decision about allocating resources within one’s lifetime.5 This decision is constrained by an interpersonal distribution that assigns fair lifetimeshares, on grounds independent from the intrapersonal allocation.6 In short, PLA budgets resources across lives; the broader distributive principle provides that budget.7 The reason for this dual-layered approach is Daniels’ view that health-related goods are special because of their “strategic importance”8 in protecting opportunities. This is also a central concern of Rawls’ theory, embodied in his principle that a just society ensures fair equality of opportunity.9 10

If everyone is subject to similar lifetime patterns, age-based differences at particular times need not be inequitable. Fair resource expenditure depends on what a prudent individual would set aside for herself at a particular age from behind a Rawlsian veil of ignorance,11 which screens out morally irrelevant facts (e.g. wealth; race; religion). Extending this assumption to age means that deliberators would prefer to improve their chances of reaching old age even if that reduces the chance of extending it.12 This is partly because you are less likely to reach old age than preceding phases of life, but also because “most important plans and projects will be largely completed” by old age.13 We cannot leave the elderly with nothing, however; prudent individuals would secure a normal “age-relative” opportunity range at each stage of their lives,14 reflecting the thought that all of us “must have sufficient resources throughout our lives to be able to do the things that we may want to do”.15

An immediate concern is that although deliberators do not know their age, they do know how ageing works. As such, they can reason that they are unlikely to reach very old age, and so can rationally allocate few resources to later years. But from a Rawlsian perspective – absent some reason to think that this calculation reflects something morally relevant – this is a failure of the veil of ignorance to adequately cloak deliberation (I address this issue in greater detail in Sections 4 and 5). One might respond that it would be imprudent to allocate almost nothing to a stage of life, even one you probably won’t reach; but this seems an overly restrictive view of prudence. Daniels recognises this problem, and suggests supplementing the prudential model with the idea of ‘accountability for reasonableness’: since no allocation decisions can be entirely beyond reasonable disagreement, decision-makers must be prepared to defend decisions in a publicly transparent, fair deliberative process.16 Still, if some reasonable versions of prudence allow for hardship at some points in life, we can only rule out allowing hardship for particular ages on the basis of reasons other than prudence.17

Another key element of PLA is the “complete lives assumption” (CLA).18 This involves deliberators assuming they will live through all stages of their life, and that everyone will have an equal lifespan. Since all ages are equally likely, probabilistic biases such as the one described above are eliminated. Individuals of different ages can also represent stagesof a single life, as required by the reduction of the interpersonal problem to intrapersonal prudence. If we know that we must all live through the same stages, it is clear how we might see our ourselves in people of different ages.

But CLA is problematic. Wherever we set the threshold of a ‘complete life’, probabilistic calculations will creep in above it. If we set it sufficiently high to avoid this worry, its prudential status is questionable; most of us will notlive so long.

Additionally, agents who reason according to CLA cannot rationally leave resources to insure against *life-threatening* illnesses; assuming you will live through all stages of life requires that you cannot die prematurely. Daniels acknowledges, but elects to “abstract”, from the issue of early death.19 This suggests that CLA is a kind of idealizing assumption, which we must abandon when we incorporate non-ideal aspects of reality.

Daniels’ explanation of accountability for reasonableness includes the stipulation that decisions must be open to publicly scrutinisable mechanisms of appeal and revision.20 So one might wonder whether we couldn’t ‘top up’ the resources for life-threatening illnesses at this later stage by appealing against decisions that were justified by CLA, but which ignored the relevant fact of premature death.

This raises a more fundamental problem, outlined by Lazenby. CLA is both a simplifying assumption that we must abandon to apply the theory, anda framing assumption that shapes the theory. On abandoning CLA, deliberators must abandon the intrapersonal view. Young people cannot assume that allocations to older generations are equivalent to allocations to their own futures, since they might die before old age. Since that assumption justified transforming the interpersonal problem into an intrapersonal issue, abandoning it entails abandoning the theory. As Lazenby puts it, “Daniels’ solution appears successful only because it has avoided the central problem it set out to answer”: intergenerational distribution.21

The next section considers whether a Rawlsian view can work without CLA. Lazenby embraces the prudential calculations that worry Daniels – and which CLA aims to avoid – because they reflect something morally relevant: those who die young are worst off in lifetime terms, and so deserve preferential treatment according to Rawls’ difference principle.

A direct application of Rawlsian theory to healthcare involves two levels. First, there are Rawls’ substantive principles: everyone must have maximal equal liberty; and inequalities in ‘primary goods’ – goods one would want no matter what one’s life plan – are allowed only if they benefit the worst off, and are attached to offices and positions for which there is fair equality of opportunity.22 Second, there is the more abstract mechanism of the veil of ignorance. Lazenby assumes both that Rawls’ substantive principles apply, without alteration, to individuals with different lifespans, and that we should use the standard Rawlsian machinery to reach conclusions about healthcare. Section 3 suggests that the phenomenon of young, terminally ill patients undermines the first assumption; Section 4 claims that the structure of aging presents a pressing structural issue for the veil of ignorance.

**3. The young terminally ill as worst off**

This section has two aims. The first is to explore the implications of applying the difference principle to the case of the young terminally ill, as Lazenby suggests. I show that Rawls’ *substantive* reasons for preferring a difference principle do not readily apply to such cases. The second is to suggest that deliberators behind the veil of ignorance would not acceptthe difference principlein such circumstances. The *procedural* argument for the difference principle thus also fails.

The difference principle permits lifetime inequalities in primary goods only if they benefit the worst off, or are necessary to protect a system of equal liberty for all.23 It is no easy task to identify who should fall into the category of the worst off for healthcare prioritisation,24 but Lazenby suggests that if “those who have short life expectancies are in the worst-off group…the difference principle clearly demands that any whole lives inequality must be to their benefit”.25 Those with short lives are relevantly worst off not because their ill health causes them to suffer, since the difference principle applies only to “social and economic inequalities”.26 Rather, it is because they have less time, and less opportunity within that time, to acquire primary goods.

It is important to stress, however, that the difference principle objects to *any* inequalities in primary goods that do not benefit the worst off. Focusing on this highlights how problematic it is to apply Rawlsian principles to health needs.

Rawls’ central question is how to distribute wealth and income. Since the talents that enable some people to do better than others are morally arbitrary, we should allow deviations from equality only insofar as these are necessary to motivate people to greater productivity, and so increase the overall level of goods in society; and then only if this benefits the worst off.

Consider two kinds of people who might object to inequalities in Rawls’ just society. First, there are people whose talents are in principle sufficient to earn more – that is, they are talented enough to be able to fulfil roles that come with greater rewards – but who lose out in a fair competition with others. For instance, if two people of roughly equal talents apply for a job that comes with significant rewards, only one can get it. The other may then have to take a job with lower rewards that does not demand the full exercise of their talents. Then, there are people who simply have little talent. On the standard Rawlsian analysis, we have something to say to both groups. To the talented, we can say that they had a fair opportunity to earn more primary goods than they currently do when they competed with others for sought-after roles, and that they will have further fair opportunities in the future. To the naturally untalented, some of whom are likely to be among the worst off, we can say that although we could distribute things more equally, this would make them absolutely worse off.

These responses suggest some important assumptions about these individuals. First, deficits that cannot be improved – such as unavoidable deficits in talents – can be *compensated* by giving people greater amounts of wealth and income.

Second, everyone’s position is capable of being improved. Improvements in the overall level of resources in society can in principle be reflected by improvements in the absolute position of the worst off, so long as we structure things the right way. In principle, we could even establish a situation where the untalentedare the ones who earn most, and the talented earn less, because inequalities in this sense are purely distributional. Our reason for not operating such an inversely unequal scheme is not that it is not *possible* to benefit the untalented the most, but that it leads to a significant reduction in primary goods.

Finally, uncompensated inequalities in primary goods can be problematic in the Rawlsian scheme because they impact citizens’ *competitive advantage* for jobs and offices to which further benefits are attached. This in turn tests “the strains of commitment”27 for compliance with the rules of society.

Aside from the view that inequalities inherently require justification, none of these assumptions holds when it comes to the young terminally ill. This has great significance for the plausibility of the difference principle as Rawls and Lazenby present it, *even if* we accept the propriety of Rawls’ veil of ignorance mechanism (I address that distinct issue in Section 4). If we judge the worst off by looking at lifetime primary goods, some young people with debilitating terminal illnesses are *unavoidably* in that category; their position faces impediments to compensation and improvement that do not exist in the standard Rawlsian analysis. For these individuals, normal Rawlsian assumptions about competitiveness and strains of commitment do not apply. This undermines the extension of Rawls’ substantive principles to healthcare, and leads to problems for the difference principle in general.

I do not intend the following discussion to capture the experience of everyone with a terminal illness. Since our focus in the Rawlsian picture is on the very worst off, it is legitimate for the sake of discussion to assume quite significant restrictions on capacities, and very short life expectancy, since both of these limit one’s access to primary goods and hence qualify the individual for ‘worst off’ status in a way that the conditions of those with less debilitating illnesses do not.

Even ignoring pain and physical discomfort, the situations of some terminally ill people can only be marginally improved, if at all, by offering them additional primary goods. Many of the benefits that we ordinarily associate with having a greater quantity of primary goods are simply not relevant to people with terminal illnesses. A lack of primary goods will not restrict the ability of those with the most debilitating illnesses to integrate in society; their illness already does this, keeping the sufferer bed-ridden and unable to engage in significant social integration.

The existence of inequalities that do not directly improve their position are far less likely to test the strains of their commitment, because their ill health means that they are vulnerable to and dependent on others. Rawls’ stipulation that offices and positions should be accessible on the basis of equal opportunity simply does not apply to individuals with debilitating illnesses. Such individuals may be just as talented in a variety of ways as other people in society; and yet for those with the most debilitating illnesses, it makes little sense to demand that they be given an equal opportunity to access such positions; what they lack is not necessarily talent, but the capacity to exercise whatever talents they have. We cannot change this fact by even quite fundamental a reordering of the social structure.

A further difference such individuals exhibit is that their position in terms of primary goods is not amenable to compensation. Their health deficits do not just restrict their ability to *acquire* primary goods – as a deficit in talents might – but rather considerably curtail their ability to make any *use* of primary goods. For Rawls, the central attraction of primary goods – the reason that we want more of them almost no matter what our life plan is – is that they can be put to generic use in pursuing almost any life plan. But people with the most severe terminal illnesses, while they certainly might have hopes, dreams or even ambitions, cannot in this sense have a realistic life plan both because their life will very soon end, and their condition deprives them of the ability to realise even relatively modest plans. As such, it is false that a deficit in primary goods curtails their ability to carry out their life plan; rather, both their deficit in primary goods shares a common cause with their inability to realise a view of the good: their illness.

A potential response to this is that if someone’s life will be very short, we should try to fit a lifetime’s *worth* of primary goods into whatever time they have. But in the very worst cases, even this is not possible. Some primary goods, such as the opportunity to access certain social positions, are simply not relevant to those with debilitating illnesses. Others, such as the social bases of self-respect, are not obviously such that we can simply add a larger quantity at any particular time in order to make up for a lifetime deficit. What would it even mean to say that we ought to give someone a lifetime’s worth of the social bases of self-respect in the few weeks or months that they have left to live?

One thing that we clearly could give more of to the terminally ill is the most generic of primary goods: money. But remember that for at least some terminally ill young people, their position is not only impervious to indirect compensation, but also to direct improvement. Money will not be able to extend everyone’s life. And while money might be spent on improving what little time people have left – e.g. by flying distant relatives in to be by their bedside, or funding fun and/or enriching experiences, insofar as they are available – there may for the very worst off be a cap on how much enjoyment or value they can get out of such experiences. Diverse though money may be, it is limited in its power to help some people.

Amartya Sen makes a related critique of Rawls’ view,28 suggesting that giving people large bundles of resources cannot alter some people’s inability to convertresources into genuine value. But whereas Sen is thus interested in changing our currency of justice from resources to ‘capabilities’, my point is simply that there are some people who are to some degree removed from the typical purpose of giving additional resources to the worst off; unlike the cases in which Sen is primarily interested, this cannot be ‘fixed’ by the rest of us intervening to improve their conversion ability.

What this means is that unlike the worst off in Rawls’ original discussion, who could in principle have very different levels of primary goods in a way that would always be to their benefit, at least some of the very worst off in the real world cannot improve their current position because they challenge Rawls’ assumption that we will always benefit from more primary goods. For the same reason, improvements in the overall resources of a society may not be capable of improving the positions of those who are among the worst off because of severe health problems at a young age.

However, this does not mean that we can do nothing about their *relative* positions. We can, in fact, still follow Rawls’ difference principle, as Lazenby advises, by insisting that we should not seek any increase in lifetime primary goods for those whose lives will *not* be cut short by illness (i.e., the rest of us) unless those improvements will improve the lot of the worst off (i.e., those who will die young because of unavoidable terminal illnesses).

Given the significant misfortune of some people in this latter category, this includes a great deal of our current spending on improving and even lengthening our lives.29 Some inequalities in lifetime primary goods are such that attempts to eliminate them would undermine the basic ability of a society to function, or lead to a shortage of medical staff; perhaps the terminally ill would be even worse off in these cases, rendering these inequalities justified according to the difference principle. Since liberty has lexical priority in Rawls’ scheme, inequalities whose elimination would require infringement of basic liberties are also acceptable. But the degree to which the difference principle would tie the fortunes of everyone to the position of the terminally ill is still extreme.

Of course, whatever we intuitivelythink of this implication, a committed Rawlsian might insist that if this is what the difference principle delivers, then this is what is just. The reason for this is that it is what would be chosen by deliberators in the original position, and this procedure simply *defines* what is just; our intuitions to the contrary are not relevant. Contrary to such a response, however, I will now suggest that deliberators in Rawls’ original position would not choose the difference principle in such circumstances.

I have suggested that people with the most debilitating terminal illnesses are to some degree removed from the concerns that motivate a focus on the worst off for Rawls, particularly if they are very young. This has a further implication: deliberators would not be concerned that they would be unfairly excluded from certain offices, or the related benefits, by a failure to allow inequalities only if they benefitted the worst off. This is because the disconnect between the society’s general wealth and the prospects of the terminally ill means that they cannot reasonably claim that inequalities that do not improve their position constitute a sacrifice of their interests to benefit the better off. Our willingness to countenance such inequalities does not reflect a willingness to sacrifice the interests of the terminally ill, but a recognition of the currently unavoidable cap on their interests. The worst off in Rawls’ imagined society (which lacks ill health) are entitled to feel begrudged at inequalities that do not benefit them, since they could in principle have their positions improved or compensated. It is not appropriate for those whose position cannot be improved or compensated to have the same reaction; a willingness to countenance inequalities between them and us does not benefit us at their cost, because there is nothing that could be done to help them.

Finally, the possibility of suffering a debilitating terminal illness means that deliberators would take a different attitude to some risks than Rawls assumes. Rawls claims that deliberators would apply a principle of ‘maximin’ in their prudential reasoning, which ensures that the worst possible position they could occupy is as good as possible, rejecting inequalities that do not serve this purpose. They would reason this way because they are entirely ignorant of the probabilities involved, and so are highly risk-averse. But this does not apply when deliberators know that the worst position they could occupy is one of severe, debilitating terminal illness in their youth. For deliberators would be able to reason that their odds of actually being in such a position are quite low. They will have no precise odds, but since they are permitted to assume that they live in a functioning society, they can assume that only a minority of people suffer a debilitating illness. As such, it would not be rational to tether all their possible outcomes to such a position; indeed, since the position of the worst off is non-improvable, and such that it is not subject to Rawls’ typical considerations in favour of the difference principle, a genuinely risk-averse deliberator would *not* gamble on being amongst the terminally ill. The difference principle thus loses its support from *procedural* considerations, as well as the substantive problems suggested earlier.

One might think that because of the significant differences between the worst off in Rawls’ society and the terminally ill, as I have outlined above, the latter might qualify as a distinctive case whom we are justified in excluding from the Rawlsian deliberation mechanism.30 In other words, the possibility of having an incurable, debilitating terminal illness is not one that deliberators about justice should have to consider. If this is right, then the difference principle would have us tie inequalities not to the condition of individuals whose position cannot be improved, but to the next worst off.

Simply excluding the worst off because they lead to problems for a theory would, of course, be *ad hoc*. Rawlsians would need to show that the terminally ill lack some feature that is a requirement for being a deliberator, not simply that they are problematic. One potential candidate is Rawls’ requirement that those who enter the original position will have an “interest in advancing their determinate conceptions of the good”.31 If they really cannot benefit at all from additional primary goods, perhaps the young terminally ill will lack such an interest.Since deliberators *do* have such an interest, they can know that they are not in this group, and ignore such debilitating illness as a possible outcome.

Let us assume for the sake of argument that this is a principled exclusion; people in such dire straits are simply not subjects of justice, and so may be properly excluded from the original position. A proper application of Rawlsian theory would then imply that we must tie all inequalities to the benefit of the worst-off group that canplausibly have an interest in their view of the good. The implications of this depend on exactly what we mean by ‘a view of the good’. For instance, perhaps having a preference about whether one lives for a month rather than just another week counts as having a view of the good. In this case, some individuals who can have a view of the good will *still* be such that they are still not capable of pursuing many of the social opportunities that are central to Rawls’ theory, such as competition for offices and opportunities. Unlike the very worst off, they are capable of benefitting from additional primary goods, since their life could be extended. Yet someone in this position might *still* face a significant cap on their interests; once we have extended their lifespan to a month, they essentially take the place of those individuals whose position cannot be improved at all, and so there will still be a great many inequalities in primary goods that do not benefit them.

On the other hand, we might insist that a view of the good requires that one will survive for somewhat longer. I am not sure what would warrant such a restriction of the definition of a view of the good, but it is worth considering the implications nonetheless. The worst off on this view might be those who are currently expected to die young, but who could, perhaps with considerable investment of healthcare resources, live for much longer. Such individuals arein one sense capable of integration in society, and of benefitting from more primary goods. While they are not capable in their current state of ill health, they will become capable if we invest significant resources in improving their health.

Furthermore, it may seem that such individuals could feel justifiably aggrieved at our willingness to allow inequalities that do not benefit them. Remember that the worst off in Rawls’ imagined society will rightly feel aggrieved at inequalities that do not benefit them because we *could* have benefitted them. This substantive consideration thus also seems to apply to the issue of those who

However, one of the reasons that Rawls thinks deliberators will care about being able to justify inequalities to the worst off is that failure to do so will test the strains of commitment. And it is less clear whether this factor speaks in favour of applying the difference principle in the scenario currently being considered. This question depends on how far one thinks Rawls’ appeal to the strains of commitment is *pragmatic* rather than strictly normative. A pragmatic reading is supported by the fact that Rawls speaks of the strains of commitment by saying of deliberators that “when we enter an agreement we must be able to honor it even should the worst possibilities prove to be the case”.32 What matters on this view is that deliberators are actually able to live in a society governed by the rules they choose. But someone who isdebilitatingly ill – even if they *could* be made better – is not such that they could meaningfully fail to honour the principles of their society, and so will not count as testing the strains of commitment.

A normative reading, on the other hand, would suggest that when we introduce the idea of vulnerable people to our society, we must consider what they *would* refuse to live by, if they could meaningfully refuse. Such an extension may be justified; but it cannot be justified by appeal to the *actual* strains of commitment participants might feel. Rather, it must appeal to a more fundamental reason. That fundamental reason is, it would seem, the appeal to maximin reasoning.

I have already suggested that when the worst off are defined as those whose positions cannot be improved, deliberators would not pursue maximin reasoning. Some of those assumptions do not apply as strongly here; the individuals we are now considering are capable of having their position significantly improved, so some of Rawls’ substantive considerations in favour of the difference principle may apply. But deliberators can still assume that their society is functioning, and so can still assume that most people are not seriously ill. While tying all other positions to the worst off is not *obviously* irrational in the way that it is if their position cannot be improved, Rawls’ key assumption in favour of extreme risk-aversion does not apply. So again, it is not realistic to think that deliberators behind the veil of ignorance would reject all inequalities that did not benefit those with debilitating illnesses, even if those illnesses were in principle curable.

It is worth reiterating that I do not in fact see any principled reason to define the worst off as those whose position can be *substantially* improved, rather than only minimally. And if we include the latter individuals, all the problems I have outlined in this section are relevant. But even if there is some justification for considering only the former, and some of Rawls’ substantive arguments in favour of equality become relevant, it is still unlikely that deliberators in the original position would endorse those arguments, because they would have no reason to be risk-averse with regard to those outcomes.

## 4. Ageing and probability

The previous section outlined some problems with applying Rawlsian principles to a society that contains significant health problems. But even if we should not accept Rawls’ substantive principles, Lazenby might still claim that the ­decision-mechanism of the original position is appropriate, and that it has implications for intergenerational justice in healthcare. There are two key differences between Lazenby and Daniels’ views. First, Lazenby’s deliberators consider the allocation of health-related goods at the same time as all other goods. Health-related goods are no longer special, and their distribution can be seen as part of setting one's fair lifetime shares, not as a separate allocation within that structure.

Lazenby suggests that deliberators could make probabilistic adjustments to their prudential allocation, preferring younger ages. This is because of the very reasons, outlined in Section 1, that motivated Daniels to introduce CLA. To recap, despite being ignorant of their actual ages, deliberators wouldknow some basic facts about ageing: that all of us begin our lives as infants; and that we are necessarily less likely to reach any particular year of age An than we are to reach year An-1 ­because we must live through An-1 to reach An. So they can reason that it is more likely that they will be young than old, and prefer allocating resources to younger people. Lazenby thus embraces the implication that worried Daniels.

This conclusion depends on the second important difference between Lazenby and Daniels, which is Lazenby’s abandonment of CLA. Note, however, that Lazenby’s conclusion depends on an *incomplete* abandonment of CLA. CLA has two components: the assumption that all individuals will live to the same age, and the assumption that all live through each stage of life. Lazenby’s analysis works if we abandon only the first. But it fails if we also drop the second.

According to the original Rawlsian formulation, when the veil of ignorance lifts a particular deliberator may find that she is already old, just as she might find herself at any station in society, and with any plan of life. This would make her youth *even more* prudentially irrelevant to her than very old age would be if she turned out to be young; while young people may not reach old age, old people will definitely never be young.

In fact, this has some rather odd implications. If deliberator D is fifteen, each further year of age (An) has positive value in her prudential calculus. If D is eighty, many ages have *no* prudential value for her, since they have passed. It is still true that A80 has a lower priority for a fifteen-year-old than A15­ does, since she may not survive that long. But it has a greater prudential priority than A15 has for an eighty-year-old, since there is *no* chance she will ever be fifteen again.

One might think that because everyone who is eighty was once fifteen, but not all fifteen-year-olds will reach eighty, there are more total people at A15 than A80. But this tells us only that more people will necessarily be fifteen than eighty *in all of history*. D couldbe in a society which has been subject to significant demographic ageing, with more old people than young; so she cannot ‘work out’ her age based on these assumptions.

With no knowledge of her actual age, D should come up with multiple prudential allocations, one for each age she could be. Each age’s overall weighting will be a function of the weight it gets in each plan. Since A15 receives zero weighting in most plans, it gets an overall low weight. A80 features in most plans, but with a low weighting in many. The highest priority age will appear in many plans, and be likely to be reached *from* many ages. I suspect this will be some point in middle age. But whatever particular age range is chosen by the reasoning I have described, it reflects nothing of moral relevance, and is precisely the kind of arbitrary calculation the veil of ignorance is designed to avoid.

Consider an analogy with a case that concerned Rawls: religion.33 The point of hiding facts about deliberators’ religions, and the religious makeup of society, is to mark our sense that religion is morally irrelevant to distributive justice, but relevant to prudential calculations. But now imagine that after doing our utmost to hide facts about religious affiliation from deliberators, we find that because of various structural facts about religion, one affiliation would be a significantly safer bet than others. The proper Rawlsian conclusion is not that justice, surprisingly, demands that we prefer members of that religion after all, but that the method had failed to achieve its purpose. If my conclusion is right, then something similar can be said about the neo-Rawlsian analysis of age. So not only do Rawls’ substantive principles fail in the face of ill health, as argued in Section 3; Rawls’ fundamental theoretical machinery fails to cope with ageing.

**5. A final Rawlsian response**

Lazenby assumes that Rawlsian deliberators would be able to make probabilistic assumptions that make it rational for them to prefer allocating resources to earlier ages. I said that this follows only if we retain part of the Complete Lives Assumption. When we abandon CLA completely, Lazenby’s conclusion does not follow; further, Rawls’ theoretical mechanisms come under significant pressure.

Clearly, this relies on the claim that it is arbitrary to only partly abandon CLA. Lazenby does offer an argument for prioritising young people that is somewhat independent of the Rawlsian machinery, and which may thus justify his partial abandonment of CLA.34 If we can motivate the requirement that deliberators assume they will live through all parts of their life, this would warrant the probabilistic assumptions Lazenby uses, and which I have rejected as unfounded. The ground for this assumption is Lazenby’s claim that although young people cannot plausibly identify their own old age in current elderly people (as Daniels imagines), old people can reasonably identify their own youth in young people, because they have necessarily been young.

One idea that Lazenby may have in mind35 is that deliberators who are considering the possibility that they may turn out to be elderly should at least be ‘willing to will the means that must have been in place to enable them to arrive’ at any particular age’. It is surely unfair, for instance, for someone who has benefitted from a youth-oriented distribution of resources that allowed them to reach old age to now insist on changing to a more age-neutral distribution.

However, there are some issues with this suggestion. First, many societies undergo changes over time in their general level of wealth, and more specifically in available healthcare technologies. Lifespan increases mean that the demographic structure of society changes, so the socio-economic context for transfers to young people in the past was very different from the current context. Young people a century ago would not have faced so much competition from elderly patients, but they would also not have benefitted from a wealth of medical advancement and social infrastructure that improve health outcomes and save lives. Lazenby rightly points to the strain involved for young people to see themselves in elderly people; but there may also be a psychological strain on elderly people to see the current young as benefitting from transfers in the same way that they did in their youth.

Even if we accept the idea that deliberators should be willing to will the conditions that got them to their current age, it is not at all clear that this supports their assuming that they must live through all stages of life. This conclusion would be warranted if deliberators could reasonably deduce that their reaching old age implied that their society had policies that benefit the young more than the old. But such a conclusion is not justified behind the veil of ignorance. People can reach old age in societies that show a significant bias againstthe young. So if a deliberator is considering the possibility that she will turn out to be elderly, and agrees that she ought to endorse whatever conditions allowed her to get to that stage, this does not obligate her to endorse the conditions that she would choose *if she were in fact young*.

Finally, it is not obvious that we should always be willing to will the conditions that allowed us to get to our current age. For instance, McKerlie36 imagines a scenario where elderly residents of a city block live in crowded, poorly managed retirement homes, while affluent younger people live in pleasant apartments. If the apartment residents will one day end up in the retirement homes, and the retirees once lived in the apartments, this case involves *lifetime* equality, but is still problematic from the perspective of egalitarian justice. It also seems to be a case where even though the elderly residents benefitted from a similar inequality when they were young, it may not be just to *perpetuate* that inequality.

Lazenby does offer some independent reasons to think that deliberators should set something aside for old age. He suggests that allowing the elderly to be very badly off will test the strains of commitment, and that deliberators “would want to allow themselves some opportunity to revise their conception of the good at later stages in life”. This point does soften the concern about hardship in old age somewhat. But it is in considerable tension with the assumption that deliberators will live through all stages of their lives, which is a requirement for Lazenby’s probabilistic reasoning. Why should deliberators leave room for themselves to change their conception of the good in very old age if they are so very unlikely to make it to that age, as is the case if they must assume that they will start from birth? From their perspective, they must assume that it is vanishingly unlikely that they will reach certain ages, and so have little reason to allocate sufficient funds to maintain quality of life at that age.

The claim that such a distribution would test the strains of commitment is more plausible. But Lazenby suggests that this only prohibits leaving people “unbearably badly off”, an idea also found in Callahan’s related defence of age-related limits on healthcare (cf. fn10). This appeal to the extremities of the unbearable ignores the possibility of the kind of time-relative claims of egalitarian justice that McKerlie’s example raises,37 according to which the strength of people’s distributive claims depends partly on their state at particular times, as well as how their lives go overall. Such a view recognises that it is possible for someone to have hadmany opportunities and valuable experiences over their lifetime, but to now be in a position where they are without much at all. And it suggests that there may be an egalitarian objection to this.

Some understand this concern as a worry about relative inequality at particular times; McKerlie and Temkin, for instance, both worry about societies where people’s lives are roughly equal in quality, but only because they trade places between very good and very poor lives at different stages. As Bidadanure38 notes, such a claim may also gain support from the concept of ‘relational’ justice, the idea that certain levels of inequality may contribute to unjust social relations between individuals.

But one can also understand the time-relative claim as objecting to people suffering certain absolutely bad states at particular times, even if there is no overall lifetime inequality. One reason to accept such a view is that the benefits we incur through various forms of social intervention and redistribution are not only benefits in a lifetime sense; they also, typically, meet needs at particular times. This is far more obvious when we consider goods other than life-extending interventions. When we consider someone’s need for pain relief, for instance, we do not typically consider the pain relief as contributing to a *lifetime free from pain*; rather, we consider what pain relief will mean to them at a particular time. Taking this perspective does not rely on a person’s situation being unbearable; the fact that they have a present, pressing need is a reason to help them. The benefit is conceived of as an intervention at a particular time, not (solely) as contributing to a lifetime score.

One might argue that while this is all very well for pain relief, it does not apply to life-extending interventions. Such interventions, after all, are explicitly aimed at extending lifetimes, and so are naturally thought of from a whole-life perspective. One might further think that whereas we can talk meaningfully of a complete life, a normal lifespan, or even of a ‘fair innings’,39 similar ideas cannot apply to pain. But this is mistaken; an intervention that extends life, thereby providing a benefit that is rightly assessed from a 'lifetime' perspective, can also be seen as saving someone’s life at a particular time. Having your life saved is not only valuable because it contributes to a running total of years lived; life-saving is valuable because it maintains a capacity to engage with the various things we value at particular times. And this, of course, is a capacity that many elderly people retain. Moreover, even if it is natural to think about pain from a momentary perspective, it is also coherent to consider different individuals’ lifetime experiences of pain, and to raise egalitarian concerns about differences between them.

I have not offered a comprehensive defence of time-relative egalitarian claims. The worry with Lazenby’s view is simply that it seems to rule them out by fiat. Because deliberators must assume that they will start their lives at birth, they are forced to think about their old age from a distant perspective, and hence only as a contributor to the quality of their whole life. An alternative view might give weight both to lifetime and time-relative perspectives in assessing the overall weight of individual claims.40

**6. Conclusion**

I have argued that two central Rawlsian attempts to address intergenerational justice in healthcare are deeply problematic. As Lazenby notes, Daniels’ attempt to establish a separate mechanism to address healthcare runs into problems with his conception of the agents involved. But Lazenby’s suggestion that we should slot healthcare concerns into mainstream Rawlsian theory also faces problems. The fact that some people have debilitating terminal illnesses at a young age creates problems for Rawls’ substantive and procedural defences of his difference principle. And the structure of human ageing allows probabilistic calculations that upset the basic structure of the original position, a problem that cannot be plausibly avoided by stipulating that deliberators must assume that they will begin life at birth. As such, I suggest that neo-Rawlsian attempts to incorporate health, illness and ageing face some challenges of sufficient significance to warrant looking elsewhere for a theory of justice.

**Notes**

1 John Rawls, A Theory of Justice: Revised Edition (Harvard University Press: Massachusetts, 1999).

2 Hugh Lazenby, ‘Is Age Special? Justice, Complete Lives and the Prudential Lifespan Account’, *Journal of Applied Philosophy*,28, 4 (2011): 327-40

3 Norman Daniels, ‘Health care needs and distributive justice’, *Philosophy and Public Affairs*,10, 2 (1981): 146-79; *Just Health Care* (CUP: Cambridge, 1985); *Am I My Parents’ Keeper?* (Oxford: OUP, 1988); *Justice and Justification* (CUP: Cambridge, 1996); *Just Health* (CUP: New York, 2008a).

4 Daniels’ theory has changed considerably over time; the particular form I will discuss is that which Lazenby takes as his target.

5 Daniels 1996, 259

6 ibid., 263-4

7 ibid., 260

8 Norman Daniels. 'Justice in health care’ in *Health Care Ethics*.D. Van De Veer and T. Regan (eds.) (Philadelphia: Temple University Press, 1987). 290–325. p.312

9 John Rawls, *Justice as Fairness: A Restatement* (Cambridge, MA: Harvard University Press, 2001), pp.42-43

10 For other criticisms see James Wilson 'Not so special after all? Daniels and the social determinants of health’ *Journal of Medical Ethics* 35, 1 (2009) pp.3-6; Shlomi Segall ‘Is Health Care (Still) Special?’ *The Journal of Political Philosophy.* 15, 3 (2007): pp.342-361.

11 Rawls 1999, 11

12 Daniels 2008a, 1781

13 Dan Brock, ‘Review: Justice, Health Care, and the Elderly’, *Philosophy & Public Affairs*,18, 3 (1986): 297-312, p.303. See also Daniel Callahan, *Setting Limits* (Georgetown University Press: Washington, 1995).

14 Daniels 1996, 214

15 Juliana Bidadanure, ‘In defense of the PLA’, *The American Journal of Bioethics*,13, 8 (2013): 25-27, p.26.

16 Daniels 2008a, 117-39

17 Dennis McKerlie, ‘Justice between age-groups: a comment on Norman Daniels’. *Journal of Applied Philosophy*,6, 2 (1989): 227-34

18 Lazenby 2011: 331

19 Norman Daniels. Justice between adjacent generations: further thoughts’. *The Journal of Political Philosophy* 16, 4 (2008b): 475-494.

20. Daniels 2008a: 131-2

21 Lazenby 2011: 333. Also Greg Bognar, ‘Fair innings’, *Bioethics* 29, 4 (2015): 251-61, pp. 258-9.

22 John Rawls, *Justice as Fairness: A Restatement* (Cambridge, MA: Harvard University Press, 2001), pp.42-43

23 Rawls 1999: 65-66

24 Dan Brock, ‘Priority to the Worse Off in Health Care Resource Prioritization’ in R Rhodes, M Battin and A Silver (eds.) *Medicine and Social Justice: Essays on the Distribution of Health Care* (Oxford: Oxford University Press, 2012), pp.155-165

25 Lazenby 2011: 337

26 Rawls 1999: 53

27 ibid: 153

28 Armatya Sen, Inequality Re-examined (Oxford: Clarendon Press, 1992), pp.26-28; 36-38

29 Kenneth Arrow, ‘Some ordinalist-utilitarian notes on Rawls’s Theory of Justice’, *The Journal of Philosophy*,70, 9 (1973): pp.245-63 makes a related criticism.

30 An anonymous referee made this suggestion.

31 John Rawls, ‘Social unity and primary goods’ in Samuel Freeman (ed.) *John Rawls: Collected Papers* (Massachusetts: Harvard University Press, 1999), p.365

32 Rawls 1999: 153

33 John Rawls, *Political Liberalism* (New York: Columbia University Press, 1996), p.311

34 Lazenby 2011: 337-8

35 An anonymous referee made this suggestion.

36 Dennis McKerlie, *Justice Between the Young and the Old* (New York: OUP, 2013), pp.6-7

37 See also Larry Temkin, *Inequality*, (Oxford: OUP, 1993), pp.232-244; Klemens Kappel, ‘Equality, Priority and Time’, *Utilitas* 9, 2 (1997): 203-225; Kasper Lippert-Rasmussen, ‘Measuring the disvalue of inequality over time’, *Theoria* 69, 1-2 (1997): 32-45; Nils Holtug, *Persons, Interests, and Justice* (Oxford: OUP, 2010): pp.316-325; Nancy Jecker, 'Justice between age groups: an objection to the prudential lifespan approach', *American Journal of Bioethics*, 13, 8 (1997): 3-15; Paul Bou-Habib, ‘Distributive justice, dignity, and the lifetime view’, *Social Theory and Practice* 37, 2 (2011): 285-310.

38 Juliana Bidadanure ‘Making sense of age-group justice: A time for relational equality?’, *Politics, Philosophy and Economics* 15, 3 (2016): 234-60

39 John Harris, *The Value of Life* (London: Routledge, 1985), p.91

40 I lack the space to discuss this idea in detail; see Ben Davies, ‘Fair innings and time-relative claims’, *Bioethics* 30, 2 (2016): 462-468.

*Ben Davies, Department of Philosophy, Bloomsburg University of Pennsylvania.*

[*bdavies@bloomu.edu*](mailto:bdavies@bloomu.edu)

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