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Commentary on Prof. Singer's Lanson Lecture 2022
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Utilitarianism, prioritarianism, and the Covid pandemic

Let me begin by stressing what an honour it is for me to be given the opportunity to respond to a philosopher and bioethicist as distinguished as Prof. Singer, who can claim to have influenced – I think I can say positively influenced! – the thinking and the behaviour of so many people around the world, including myself. In my commentary on Prof. Singer's lecture, I would like to further explore certain issues relating to the fair allocation of Covid vaccines, as well as to cosmopolitan and utilitarian approaches to public health policy. I will need to set aside other important issues raised in the lecture: for instance, the issue of how to prevent future pandemics is no doubt of great significance, and Prof. Singer's remarks force us to think about how it might intersect with the ethics of using animals for food. I personally think – and I guess Prof. Singer might agree – that this particular conversation should be even broader in scope, given the uncertainty still surrounding the origins of the Covid-19 pandemic. Yet as I do not wish to detract our attention from Prof. Singer's points, as well as for reasons of time, I will not pursue this issue further here. Nor will I discuss whether we already have enough evidence that a sufficiently high rate of vaccination cannot be achieved, at least in some places, using alternatives to mandatory vaccination, such as offering financial and other incentives to get vaccinated, and how broad any vaccine mandates that get introduced should be – although I do believe that such issues, too, deserve to be rigorously debated.

Allocating Covid vaccines: utilitarianism and prioritarianism

Prof. Singer argues that a vaccine allocation policy aimed, in his words, at saving more lives, is preferable to the "equity-oriented" approach initially proposed by officials at the U.S. Centers for Disease Control and Prevention (CDC). However, we have seen that Prof. Singer also considers it important to maximize *life-years*, as distinct from *lives* saved, and I would find it helpful to hear more about how he thinks we should combine these two goals when designing policies for the allocation of medical resources – although they can often be

pursued together, this is not always so. Now, while I ultimately agree with Prof. Singer's assessment of the CDC's approach, I would still like to discuss what I take to be an attractive ethical principle that seems to be influencing at least some of these equity-based proposals: the principle called *prioritarianism*, or as famous British philosopher Derek Parfit called it, the "Priority View".[1]

Broadly speaking, prioritarianism tells us to give some priority (although arguably not absolute priority) in our distributive decisions to those who are identified as *worse off* in some relevant sense. Now, what is that relevant sense? Various possible metrics can be used to make such judgments, depending on the context. When it comes to tax policy, for instance, a prioritarian might equate the worse off with those in the lower quintiles of the income distribution, and go on to defend a progressive income tax. In the specific context of allocating scarce medical resources, one example of a potentially relevant, albeit controversial, dimension is *age*. Some bioethicists sympathetic to prioritarianism thus contend that, all else being equal, younger people (or at least younger adults) should receive priority over older people in the allocation of scarce, life-saving interventions like ventilators, because the former are in one important respect worse off than the latter: namely, they have enjoyed fewer life-years so far, with the opportunities for well-being that these provide.[2] (To be clear, I am using this example to illustrate what I take to be the general appeal of the idea of giving priority to those worse off, *not* to suggest that giving priority to younger people would be appropriate in the allocation of Covid *vaccines*. For the reasons outlined by Prof. Singer, in that context, it makes sense to prioritize by age precisely the other way round.)

Of course, as Prof. Singer indicated in his lecture, utilitarians can agree that it is sometimes ethically appropriate, and not "ageist", to prioritize saving younger people: namely, when doing so means securing more years of life, thus producing a better outcome. This sets limits to the scope for disagreement between prioritarians and utilitarians regarding the relevant distributive dilemmas. Nevertheless, disagreements will still emerge. Suppose for instance that we must choose between saving the life of patient A, who is 35 years old, or of patient B, who is 70, and that both can expect to live for another 20 years if they receive the

[1] Derek Parfit, "Equality and Priority", *Ratio* 10, 3 (1997): 202-221.
[2] E.g. Govind Persad and Steven Joffe, "Allocating Scarce Life-Saving Resources: the Proper Role of Age", *J Med Ethics* (2021), doi:10.1136/medethics-2020-106792; David Archard and Arthur Caplan, "Is It Wrong to Prioritize Younger Patients with Covid-19?", *BMJ* (2020): 369.

intervention – patient A, we may assume, suffers from a genetic condition that substantially shortens his life expectancy. In this hypothetical example, prioritarianism tells us to save the younger patient, whereas utilitarianism permits us to save either of the two. (When discussing the ethics of allocating ICU beds, Prof. Singer mentioned he does not think that age itself is ethically relevant.) My personal intuition is that, in this type of case, prioritarianism yields a more plausible conclusion than utilitarianism; one might argue that it is more sensitive to considerations of *fair distribution*. And my sense is that many of those who support an equity-based approach to the allocation of Covid vaccines share my prioritarian leanings – although they do not typically identify younger people as being worse off in that particular context. If so, the guiding idea behind their approach may not be unreasonable.

The difficulty, as I see it, is that prioritarianism seems most persuasive when applied to simple comparisons of this kind, but it proves much trickier to apply to more complicated cases like the allocation of Covid vaccines. Indeed, in such a context, unlike the two-person case just outlined, we will not be choosing between alternatives involving benefits of equal size. As Prof. Singer mentioned, the CDC admitted that their initial proposal to prioritize "essential workers" over Americans aged 65 and above in the rollout of vaccines would result in a larger number of deaths from Covid, given the much higher risk of dying that the virus poses to the latter group. Presumably, the total number of life-years saved would also have been different under each allocation. If so, priority to the worse off – however we define that group – cannot then simply be used as a tie-breaker between two otherwise equally good options. Rather, prioritarians will need to decide how much more ethical weight they should give to benefits accruing to those identified as worse off. Furthermore, given the difference in the number of deaths expected from each prioritization, the principle enjoining us to save the most lives becomes relevant to our choice in this case, and I agree that this principle has appeal in its own right. This means that to have any plausibility, any application of prioritarianism to the issue of Covid vaccine allocation needs to balance the potentially competing principles of saving the most lives, maximizing the number of life-years saved, and giving priority to those who are worse off (plus any other relevant principles).

The CDC's original allocative proposal identified US essential workers as being worse off than older Americans, due to members of disadvantaged ethnic minorities being "disproportionately represented" among the former group. They pointed out that about 25%

of essential workers lived in low-income families.[3] As Prof. Singer alluded to, members of such minorities also face worse health outcomes and more limited access to healthcare, on average, than white Americans do, something that is at least partly explained by their overall worse socio-economic situation (although some would also invoke "systemic racism" as a direct causal factor). Those who, like the CDC, have proposed prioritizing essential workers over older people in the allocation of Covid vaccines thus seem to reason that doing so would redress unfair inequalities in access to health benefits, and that the ethical value of this goal can justify failing to save as many lives as we could. That said, in addition to considerations of fairness and equity, the CDC also mentioned the need to "preserve services essential to the COVID-19 response and [the] overall functioning of society" in support of their proposal to prioritize essential workers.[4]

I do find Prof. Singer's critique of the CDC's original proposal persuasive. For one thing, that proposal intuitively gave too little weight to the requirement to save the most lives, in the name of redressing health inequities (a goal that some proponents have described as having huge "symbolic importance").[5] For another thing, as Prof. Singer pointed out, the proposal would even seem to fail on its own terms, insofar as it could have been expected to lead to more deaths among the very disadvantaged minorities it was supposed to prioritize. It is also not fully clear to me how the CDC's invocation of the need to protect services essential to the pandemic response fits with their acknowledgment of the fact that prioritizing older Americans in the allocation of vaccines would save more lives overall. Now, assuming that this kind of proposal is not acceptable, what should we conclude about the general approach that it typifies? Prof. Singer suggests that eligibility for vaccination could be made to vary according to race, insofar as the combination of age and race might provide the best available indicator of risk of death from Covid. Since it would give members of disadvantaged ethnic minorities earlier access to the vaccine, his proposal would *de facto* implement some form of priority to the worse off, yet it would do so for the sake of saving the most lives, and not out of a separate, prioritarian concern for fairness.

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[3] Kathleen Dooling, "Phased Allocation of Covid-19 Vaccines", ACIP Meeting, November 23, 2020, URL = https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-11/COVID-04-Dooling.pdf.

[4] Kathleen Dooling, "Phased Allocation of Covid-19 Vaccines".

[5] Harald Schmidt, "Vaccine Rationing and the Urgency of Social Justice in the Covid-19 Response", *Hastings Center Report* 50 (2020): 46-49.

Assuming Prof. Singer is correct that implementing such a proposal would also help save the most lives, it becomes unclear what room, if any, there might be for prioritarian reasoning in the context of the allocation of Covid vaccines. A possible objection to Prof. Singer's proposal might be that it fails to directly take into account unfair health disparities caused by economic deprivation. A truly fair vaccine allocation scheme, one might argue, should therefore also give some priority to those who are worse off in terms of socio-economic status, which admittedly correlates significantly with race, but still not perfectly so. One way of doing this in a context like the United States would be to prioritize access to vaccines, *within* relevant groups such as adults age 65 and above, to people living in areas scoring high on the CDC's Social Vulnerability Index (SVI), a measure that combines race and socio-economic status among other risk factors for Covid-19 mortality. A proposal along those lines was recently put forward in a report by the US National Academies of Science, Engineering and Medicine (NASEM).[6]

Let us assume we accept the premise that the relevant health disparities are unfair, so that justice requires giving some priority to those who are disadvantaged by them. To assess the NASEM's proposal, we would need to have a clearer idea of how it could be expected to fare, as compared with Prof. Singer's approach, with regards to the goals of saving the most lives, and the most life-years. Assuming both approaches would fare about equally well, I would argue that there might be a prioritarian reason to prefer the NASEM's proposal. But it would become less appealing if Prof. Singer's approach did result in more lives saved.[7] This suggests that prioritarian reasoning is most plausible in such a context if used to break a tie between otherwise equally appealing alternatives, but that it probably cannot play the more substantial role assigned by those who want to place priority to the worse off above the need to save the most lives (although it might be able to play a larger role in other contexts than vaccine allocation). That said, I do think that further reflection and debate on this issue might be worthwhile – for instance, we might wonder whether prioritizing the worse off on grounds of fairness can more plausibly outweigh the need to save the most lives if it also helps secure the most *life-years* in a given situation.

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[6] National Academies of Sciences, Engineering, and Medicine. *Framework for Equitable Allocation of COVID-19 Vaccine*. Washington, DC: The National Academies Press (2020). https://doi.org/10.17226/25917.

[7] If the NASEM's proposal were actually the one saving the most lives, Prof. Singer would presumably endorse it, and there would again be no disagreement between prioritarians and utilitarians at the policy level.

Global prioritarianism, cosmopolitan ethics, and "welfarism" in public health policy

So far, I have discussed the relative merits of a prioritarian and a utilitarian approach to vaccine allocation at the local level. That is because doing so is both simpler and more in line with common sense. Seeking to give priority to the worse off at the *global* level is arguably more controversial. For one thing, it presupposes that we adopt a cosmopolitan ethic, one that tells us not to give special weight to people from our own country or society in our ethical deliberation. Many people do not accept such an ethic, which helps explain for instance the prevailing disposition of most developed countries to seek to vaccinate their own citizens first. That said, Prof. Singer is of course known for arguing that we *should* adopt a cosmopolitan perspective, and that our ethical obligation to help those in dire need in the developing world is much more stringent than most of us usually recognize. Adopting a global form of prioritarianism would clearly place very heavy obligations of altruism upon us, requiring us to be more concerned about saving lives among the world's most disadvantaged populations than in our own country.

While I do not intend to defend such an ethical approach, I nevertheless readily agree with Prof. Singer and the World Health Organization when they tell us that more needs to be done to get poor countries the vaccines they need, whether it is via initiatives like the Health Impact Fund, generous donations to the COVAX program, or investments in local vaccine manufacturing in the developing world.[8] That said, I believe this also raises a question about how global exactly our thinking about these different issues should be. When discussing the importance of saving the most lives in the context of vaccine allocation, Prof. Singer and I both focused on what happens at the local, country-specific level. By contrast, in his discussion of the ethics of lockdowns, Prof. Singer also considered the impact of the resulting economic recession on deaths and poverty rates in developing countries. This may well be justified, yet if so, why not apply the same criteria of global impact to the question of local vaccine allocation? Such an impact might speak in favour of allocative strategies focused on quickly getting a wealthy country's economy up and running again, to help benefit the global poor, even at the expense of the country's older population, who might receive lower priority in the resulting allocation. This will look to many like a perverse and unacceptable

[8] UN News, "Vaccine Equity the 'Challenge of our Time', WHO Chief Declares, as Governments Call for Solidarity, Sharing", 16 April 2021. URL = https://news.un.org/en/story/2021/04/1089972.

implication. It is not clear, though, that moral cosmopolitans can avoid it, unless they do not want to think about local vaccine allocation in terms of its global impact – in which case further justification for such a stance would be needed.

A related point, on which I would like to conclude, concerns Prof. Singer's argument that we would ideally want to be able to evaluate different lockdown policies in terms of their overall effects on human well-being. We might again ask whether this also extends to other policies related to pandemics, such as policies about vaccine allocation. Regardless, I appreciate Prof. Singer's remarks about the desirability of a single metric that would allow us to precisely compare costs and benefits of very different kinds, such as health-related vs. economic ones, rather than having to rely on rough and ready judgments, as we currently do. Yet one possible risk of a focus on overall gains and losses in well-being is that it might reintroduce the kind of objections to utilitarianism that are familiar from debates in normative ethics. Prof. Singer suggested measuring well-being in terms of life satisfaction. We know, however, that for a variety of reasons, even fully healthy people can substantially differ in the degree to which they are satisfied with their lives. In fact, racial differences under this dimension have been identified, with ethnic minorities in the US tending to be less satisfied with their lives than white Americans.[9] Assessing policies in terms of their overall impact on life satisfaction thus raises the worry that the costs and benefits to certain people in terms of life-years gained or lost might be unfairly discounted, and that this might even happen along racial lines – leading us back to the concerns about racial justice at the centre of the equity-oriented approaches to vaccine allocation that I discussed previously. It thus seems to me that it is worth thinking carefully about whether a move towards well-being as the fundamental criterion of evaluation of public health policies would really be preferable, all things considered, to the messier comparisons we use today; and if it would, whether or not it might still be desirable, out of a concern for fairness, to set limits on the kind of differences in well-being that should be taken into account in our evaluations.

[9] U.A. Mitchell, J.A. Ailshire, "Race Differences in Life Satisfaction: Do Higher Levels of Education Help or Hurt?", *The Gerontologist* 55, 2 (2015): 263.