

Sustainability, equal treatment, and temporal neutrality

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Addressing distributive justice issues in health policy—ranging from the allocation of health system funding to the allocation of scarce COVID-19 interventions like intensive care unit beds and vaccines—involves the application of ethical principles. Should a principle of *sustainability* be among them? I suggest that while the value of temporal neutrality underlying such a principle is compelling, it is already implicit in the more basic principle of equal treatment.

ETHICAL PRINCIPLES

Munthe *et al*¹ imagine sustainability accompanying four other principles: need, prognosis, equal treatment and cost-effectiveness. Some are spelled out, however, in ways that are ambiguous or incomplete. Start with need. They suggest that more resources should go to those with more need. But they do not explain what is meant by need, and conflicting definitions exist. Frances Kamm² defines need as ‘how badly someone’s life will have gone if he is not helped’. But others define need-based distribution differently: for instance, distribution to those who are sickest right now or who will suffer harm without assistance^{3 4} or distribution that excludes consideration of non-medical factors.⁵ Kamm’s conception picks out an ethically compelling consideration, but one better described in terms of *disadvantage* rather than need.

Two other principles are easier to understand. The *prognosis* principle tells us that the more an intervention promotes health, the more resource investment in that intervention is warranted. The *equal treatment* principle is the obverse of all other relevant principles: if two claims are equal with respect to other relevant values, they warrant equal resource investment.

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Last, cost-effectiveness is also a confusing principle. As presented, it tells decision makers to meet a given need using no more resources than necessary. However, it is better understood as an implication of something like the prognosis principle than as a principle of its own.

Instead of the list of principles identified, I propose the following more parsimonious set:

- ▶ *Beneficence*: the more benefit an intervention produces, the more resource investment is warranted.
- ▶ *Remediating disadvantage*: the worse off a beneficiary would be if not aided, the more benefiting them matters.
- ▶ *Equal treatment*: if two claims are equal with respect to relevant values, they should be treated equally.

These principles or a similar tripartite set have been adopted in recent COVID-19 vaccine allocation frameworks⁶⁻⁹ and in health policy more broadly.^{10 11}

TEMPORAL NEUTRALITY AND THE VALUE OF SUSTAINABILITY

I would conceptualise the value underlying sustainability more simply, as *temporal neutrality*: when in time beneficiaries are located is irrelevant to the strength of their claims.^{10 12-14} Temporal neutrality is merely a special case of the principle of equal treatment: since the time at which someone exists is irrelevant to their claims under either Munthe *et al*’s¹ original principles or my revised alternative set, equal treatment requires that similar claimants at different times be treated similarly.

Temporal neutrality is agnostic about the set of factors that can ground claims. Accordingly, it is compatible with distributive principles other than mine or Munthe *et al*’s,¹ such as *strict egalitarianism* (all should have an equal chance to receive treatment) (Munthe *et al*, p. 19)¹⁵ *reparation* (favour beneficiaries who previously experienced injustice)¹⁶ and *desert* (favour those who acted meritoriously in the past) (Munthe *et al*, p. 18).¹ While desert, for instance, attaches no importance

to future *interests*, it is fully compatible with temporal neutrality between equally deserving present and future beneficiaries.

Although temporal neutrality strikes me as compelling, the weaker value of *future relevance* could be substituted. On this approach, future outcomes need not count the same as present ones, but they do count for something.¹⁷ Or the alternative value of temporal *sufficiency* could be substituted: all people should receive some minimum level of benefits. Unlike temporal neutrality, temporal sufficiency can stand in tension with other principles. For instance, temporal sufficiency might require providing assistance to people at a given time, even at the expense of greater benefits to people at another time. However, if temporal sufficiency accompanies a principle of remediating disadvantage, the work required by the former principle will typically already have been accomplished by the latter.

ASSESSING HOW POLICIES INFLUENCE FUTURE HEALTH NEEDS

Any temporal principle—whether temporal neutrality, future relevance, or Munthe *et al*’s¹ original principle of sustainability—faces challenges of assessment if framed in terms of health needs, rather than health outcomes. Consider the example of a programme that expands access to vaccinations (Munthe *et al*, p. 7).¹ This programme likely increases future *health*: people will suffer less illness and death from infectious disease. However, it may not diminish future *healthcare needs*: those who escape death or illness due to infectious disease may live longer and develop other conditions (such as cancer, diabetes or dementia) that in turn generate demands for costlier healthcare.¹⁸ This shift from communicable to non-communicable diseases is in fact what has happened as many developing countries have grown wealthier.¹⁹ This phenomenon makes it difficult to identify when genuinely positive or negative dynamics exist, if these dynamics are understood as a reduced or increased need for future healthcare. It is preferable to understand dynamics in terms of better future health *outcomes* at a given spending level.

The distinction between health outcomes and demands for healthcare also leaves me doubtful about the

authors' prediction of healthcare system collapse in systems that ignore negative dynamics. Healthcare demands can resolve in two ways: by being addressed by healthcare provision or by becoming unaddressable because the potential beneficiary dies or is no longer treatable. Health systems can and do persist without collapse by meeting visible and addressable healthcare demands, particularly the demands of those able to get policymakers' attention, while ignoring less visible demands, especially demands that will rapidly become unaddressable without aid.¹ As Kamm observes, 'the dead are highly invisible'²⁰; in contrast, those with expensive diseases are very visible. This can lead health systems to spend more on cancer drugs, for instance, than on interventions to address infant mortality, even when infant mortality interventions improve health far more per dollar and remediate more disadvantage (Munthe *et al*, p. 4).^{1 21} Because future health system beneficiaries are even less visible than the dead, their claims are at even greater risk of being ignored.

¹Some defend this tendency. See Bloche MG. The invention of health law. *Calif. L. Rev.* 2003;91:247, who argues that "the anguish of identified persons" should often override "population-level health maximization." See also Goodin, *op. cit.* (observing that "one explanation for why too many resources are devoted to prolonging life pointlessly for terminally ill patients is that those patients are right in front of the attending physician, whereas others on whom those resources might be better spent may often not be")

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Commissioned; internally peer reviewed.

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To cite Persad G. *J Med Ethics* 2021;47:106–107.

Received 22 December 2020

Accepted 24 December 2020

Published Online First 17 January 2021



► <http://dx.doi.org/10.1136/medethics-2020-106644>

J Med Ethics 2021;47:106–107.

doi:10.1136/medethics-2020-107186

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