"Would have died soon anyway": COVID-19, distributive justice and age discrimination

Kasper Lippert-Rasmussen is professor in political theory at University of Aarhus, Denmark, and author of Making Sense of Affirmative Action (OUP, 2020). He has published widely on ethics and political philosophy. He was associate editor at Ethics 2009-2020.

Not everyone is equally affected by contracting COVID-19. A few people are asymptomatic. Many others will get seriously ill and some of them will die. Specifically, your age makes a huge difference to how badly affected you are likely to be. In May 2020, 85+-year-old people made up roughly half of the COVID-19 deaths in England, while there were no such deaths among 0-19-year-old people. (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19englandandwales/deathsoccurringinmay2020#characteristics-of-those-dying-from-covid-19). Approximately 3% of the UK population is aged 85+.

Like other countries, the UK devotes a huge amount of resources to fighting COVID-19. First, the UK will spend much more resources on healthcare in 2020 than it did in 2019 and a great proportion of those resources will be spent on addressing COVID-19-related problems. Second, in order to reduce the number of interactions where COVID-19 can be transmitted, the UK government has imposed extraordinary restrictions on citizens with severe negative consequences for production and consumption as a consequence: "Recent ONS monthly figures showed the economy plummeted by 20.4% in April - the largest drop in a single month since records began" (https://www.bbc.com/news/business-53231851). Much of this contraction will result in people enjoying things such as dining out on Fridays less in the future, which in comparison with saving a life, is not particularly morally important. But it will also result in the UK having less resources for purposes, e.g., funding the NHS in the years to come, which, ultimately, are no less important than saving lives here and now, e.g., saving lives here and later.

The scale of COVID-19 countermeasure costs and the fact that a very large proportion of COVID-19 related deaths occur to old people, whose deaths are significantly less tragic than that of younger people, who lose far more life years from dying, has led some to ask whether the UK – and other countries – spend too many resources on fighting the COVID-19 pandemic.

A controversial report published by the Danish right-wing think-tank, CEPOS, suggested that, in view of the age-profile of COVID-19 deaths, Danish lockdown measures to prevent the spread of COVID-19 cost the Danish society "on average DKK 2.6 million per quality-adjusted life year gained" https://cepos.dk/publications/we-pay-minimum-five-times-as-much-for-a-life-year-with-the-corona-measures-than-we-normally-do/. This is roughly five times as much as what is the maximum willingness to pay for one quality-adjusted life year (QALY) gained through the introduction of new medicine in the Danish public health care system. To put things unrealistically and simplistically: if Denmark had not engaged in a COVID-19 related lockdown and instead spent the money saved in this way on providing some of the expensive forms of medicine that it did not offer patients on grounds of an unfavourable cost/QALY ratio, perhaps far more QALYs would have been gained.

Have we been spending too many resources on responding to a disease, whose victims to a very large degree have had – to use the English bioethicist John Harris' expression – their "fair inning"?

Before answering this question directly, let me correct two mistakes in background assumptions often made, when it is asked. The first mistake is to think that one can directly infer from the fact that, say, roughly 50% of all COVID-19 related deaths are of people aged 85+ that if we were to spend considerably fewer resources on fighting COVID-19 roughly 50% of the extra deaths that this would result in would be the deaths of people aged 85+. Perhaps a much higher number of younger COVID-19 patients who make it under present conditions would not make it under conditions, where many of them would not receive any hospital treatment.

The second mistake is to think that we can read off directly from statistics documenting drops in the economy or increased public health spending what net savings a country would enjoy by adopting less COVID-19 countermeasures. One reason is that much of the contraction of the economy would have happened even in the absence of any such measures, e.g., because UK exports would be negatively affected even if nothing else had changed in the UK. And because much of what else did change in the UK would have changed even in the absence of government measures, e.g., even in the absence of any prohibitions people might not have been as keen on dining out as they normally are in the midst of a corona crisis even worse than the one that we are experiencing presently. Another reason is that, to the extent that government measures have been effective in making people refrain from doing what they would have continued doing in the absence of restrictions, they might have saved us from the costs of an out-of-control, drawn-out COVID-19 pandemic, e.g., severe social unrest.

How much societies such as the UK have spent on fighting COVID-19 is an extremely complex, empirical question and philosophers rarely have expertise on such matters. Below I will simply assume that, even when we correct for the two mistakes just mentioned, COVID-19 has meant that societies now spend considerably more resources on saving the lives of old people than it did previously ultimately at the expense of the health of younger persons. So back to my main question.

One common argument for an affirmative answer to this question encourages us to assume that societies have spent exactly the amount of resources that they should spend on fighting COVID-19 and then see what else follows. If these implications are implausible, then that detracts from the credence of this idea. If they are not, then that supports this idea.

One such comparison that has often come up in public debates is a comparison with normal seasonal flus. In a tweet early March 2020, Donald Trump wrote: "So last year 37,000 Americans died from the common Flu. It averages between 27,000 and 70,000 per year. Nothing is shut down, life & the economy go on. At this moment there are 546 confirmed cases of CoronaVirus, with 22 deaths. Think about that!" (https://www.reuters.com/article/us-health-coronavirus-mixed-messages/like-the-flu-trumps-coronavirus-messaging-confuses-public-pandemic-researchers-say-idUSKBN2102GY). The great majority of these ordinary flu-related deaths are deaths of elderly persons. Thus, if the draconian measures adopted in the fight against COVID-19 are justified, then so are equally or even more draconian measures against relevantly similar seasonal flus. Since, obviously, it is unjustified to lockdown societies for weeks etc. for this purpose, it isn't – or so the argument goes – justified to spend the amount of resources that we have spent on fighting COVID-19.

Unfortunately, arguments (under the guise of invitations to think) offered in tweets are often bad ones and this one – even if we ignore that at this moment roughly 129 000 Americans, not only 22, have died from COVID-19 – is no exception. What, if anything, justifies the efforts expended in the fight against COVID-19 is first and foremost the number of lives saved as a result of these efforts. That number cannot be read off from the number of deaths in the very early, or for that matter the later, stages of an epidemic. Also, nothing rules out that the number of COVID-19 fatalities at the later stage in the pandemic would have been much higher in the absence of draconian countermeasures and, as in fact they are now despite draconian countermeasures, significantly higher than the number of deaths resulting from the ordinary seasonal flu.

We should indeed think about the figures Trump mentions and, even more so, about the much scarier updated ones. But we should do so – when we do so with an eye to how to act – because of what these figures, if anything, tell us about what would happen if we acted differently.

It is not terribly surprising that the Trump argument provides no good answer to our question. Rather than looking at tweeted arguments, perhaps we should look at the moral theories of philosophers. One such theory is utilitarianism, i.e., the view that we should maximize the sum of welfare. This view seems pretty clearly to imply that, presently, we are sacrificing too many resources on fighting COVID-19. Saving old people is likely to result in much less extra welfare than the same resources spent on saving the lives of younger people who, statistically speaking, can expect to enjoy many more life years. Another reason is that the huge amount of money spent on fighting COVID-19 in rich parts of the world could bring much greater welfare benefits if used to help people in poor parts of the world, say, by providing access to clean drinking water. Admittedly, it is very unlikely that rich countries would spend more resources on the global poor, if they were to adopt a closer to business-as-usual approach to the COVID-19 epidemic. But this is neither here nor there in relation to what they should do from a utilitarian point of view.

Of course, utilitarianism is a highly controversial theory with a lot of counterintuitive implications. One objection concerns its insensitivity to how a given sum of welfare is distributed. From a utilitarian point of view, it does not matter morally whether a sum of welfare is highly unequally distributed or perfectly equally distributed. This has led some, who are otherwise sympathetic to utilitarianism, to embrace prioritarianism.

According to prioritarianism, we should maximize the weighted sum of welfare. What this means is that the same welfare benefit has greater moral weight if it falls on a worse off person than on a well-off person. For that reason, prioritarianism is immune to the distribution-insensitivity objection. In fact, that is why, applied to the COVID-19 pandemic, prioritarianism is even more reluctant than utilitarianism is to recommend spending resources on saving the lives of elderly people. Not only will they benefit less generally speaking. They are much better off than young people in that they have enjoyed a "fair inning".

At this point, contractualists might say that due to the aggregative nature of both utilitarianism and prioritarianism, it is unsurprising that they recommend using fewer resources on fighting a deadly disease, which primarily disadvantages old people. According to contractualists, one should approach distributive questions quite differently. Rather than maximizing an unweighted or a weighted aggregation of welfare, we should compare the

complaints each individual has against a certain policy and then minimize the greatest complaint any individual has. On this view, an 85+ year-old person who loses, say, five extra life years from not being treated for COVID-19 has a more serious complaint than, say, a young person, whose life income will be somewhat reduced, as a result of government measures to fight COVID-19. Since contractualists engage in pairwise comparison of individual complaints even if a lot of people have a complaint of the latter sort, their complaints will not add up such that they morally outweigh the greater complaint of the 85+ old.

However, things are more complicated. For some of the costs imposed on others as a result of the massive amount of resources devoted to fighting COVID-19 result in losses for other people that give rise to complaints that seem no less serious than that of an 85+ year-old, who loses out on five extra life years. I have already given the example from Denmark of patients, including young people, who have been denied life-saving medicine on grounds of high cost. Also, losing one's life sounds like the basis of perhaps the most serious complaint one can possibly have. But this is too simplistic in view of the fact that, say, losing six months of extra life might not be the basis of a serious complaint compared to, say, living fifty years with an untreated depression. Hence, this impressionistic survey of three of the main philosophical theories of distributive justice supports an affirmative answer to our main question.

A final reason in defence of our expensive counter-COVID-19 measures, which I will consider, is a moral constraint against discrimination, including age discrimination against old people. It seems extremely cynical to refrain from saving people with life threatening diseases on the ground that they are likely to die soon anyway. This in itself does not amount to discrimination, since the relevant cynicism might be universal such that old people are not treated worse than others. But the point is precisely that this cynicism is not universal. Thus, an affirmative answer to our question reflects blunt age discrimination against old people.

On reflection, however, it is unclear that answering our question affirmatively amounts to an objectionable form of age discrimination. First, age discrimination against old people is very different from most other forms of discrimination in that it does not increase inequality of opportunity between individuals. Indeed, from an ex ante perspective, where we do not yet know what will happen to us, it may improve everyone's prospects.

Second, often discrimination is thought to be disrespectful in that it implies not relating to the discriminatees as equals. However, age discrimination of the sort implied by an affirmative answer to our question seems not to. One reason is that it is not as if it implies that benefits in the form of extra life years to old people count for less than similar benefits to young people. Indeed, they count for exactly the same, morally speaking. It is just the case that typically the same amount of money spent of fighting COVID-19 will result in far fewer benefits for old people than the same amount of money spent on, say, treating younger patients for other diseases. Another reason is that in extreme cases – say a case where we have to choose between treating an 85+ year-old patient with COVID-19 and another life-threatening disease from which he will die within a month or treat a 20 year-old with COVID-19 who, if treated and thus saved, will live for another 65 years – it seems very implausible to say that recommending giving priority to the young person amounts to not relating to the old person as an equal.

In conclusion, it is very difficult to estimate the benefits and costs of COVID-19 countermeasures, which is one reason among others why this article's conclusions are very tentative. Also, there are many bad arguments out there suggesting that we are using far too many resources on saving people, who are not likely to benefit much from being saved. However, at the end of the day it is not clear if that, however dreadful the COVID-19 pandemic is, it is not actually the case that, perhaps under the impression of dramatically rising fatality curves and heart-breaking pictures of crying, exhausted doctors, and stacks of coffins, we might not have overreacted, thus, putting us in a situation where we have fewer resources to deal with other persistent but less dramatic threats, including other (sometimes more) deadly threats, which fail to capture the imagination in the same way that COVID-19 has done, in large part, but perhaps not exclusively so, for good reasons.