

Choices and Consequences: A Discussion of Personal Responsibility as a Criterion for Healthcare Allocation



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Abstract

The COVID-19 pandemic has exhausted the resources of many healthcare facilities where the number of patients in need exceeds the number that can receive treatment (Everett, et al. 2021, 932). Clearly, providing treatment to one patient over another carries serious moral implications and therefore should not be done arbitrarily. Pre-pandemic discussions of healthcare allocation have involved social contract theory as a basis for (de)prioritization; under this theory, personal responsibility for one's illness was considered as a relevant criterion. Rawls, in his social contract theory imposes obligations onto individuals who derive benefits from membership in a society (1999, 96). West Virginia's 2006 modified Medicaid program offered enhanced benefits to those who signed a "member agreement" and accepted numerous lifestyle expectations, including submitting to screenings and following health improvement plans (Steinbrook 2006, 753). However, due to the numerous factors, including the social determinants which impact an individual's health, including income, education level, and employment, social contract theories cannot ethically be used to distinguish between patients. As an alternative, utilitarianism has been applied to triage guidelines in the pandemic, supposedly providing a more objective, non-discriminatory basis for treatment allocation which focuses on medical rather than personal factors (Savulescu, et al. 2021, 620). Prima facie, there seems to be a distinction regarding the role of personal responsibility across the two discussed perspectives. Namely, social contract theory directly implies that personal responsibility is a relevant criterion for medical resource allocation, while utilitarianism does not. However, given the inseparability of individuals, their social circumstances, and their subsequent health decisions and outcomes, I contend that both perspectives result in the same moral pitfalls. Further, I argue that personal responsibility ought not to be used as a criterion for healthcare allocation, whether under the application of social contract theory or utilitarianism.

I. Introduction

The COVID-19 pandemic has exhausted the resources of many healthcare facilities and has made necessary difficult decisions for healthcare providers (Everett, et al. 932). Thus, both public health authorities and medical health practitioners must make difficult choices about the allocation of funds and medical resources. While such decisions grant some individuals with potentially life-saving treatment opportunities, they also entail the denial of treatment to others whose livelihood may be contingent on treatment. Given the potential consequences of these decisions, there arises the need to establish principles which can be applied to justify choices of resource allocation. Utilitarian arguments have dominated discussions of healthcare prioritization in the pandemic, with the goal of maximizing the most lives across a large number of patients (Wang 2). However, in cases where there is no discernible difference between patient prognoses or survival chances, this perspective does not provide a basis for patient prioritization.

The idea of individual responsibility for one's own illness has been posed long before the COVID-pandemic, and some healthcare providers assent to using personal responsibility as a decision-making factor for resource allocation. For example, Norwegian and British doctors report that patient de-prioritization for care is warranted for those who engage in smoking, excessive alcohol consumption, and drug abuse (Everett, et al. 936). Further, in a national survey that was conducted in 2006, 53% of Americans reported that they thought it would be "fair" for individuals with unhealthy lifestyles to pay higher insurance premiums, deductibles, or copayments than their healthier counterparts (Steinbrook 753). Similar sentiments are expressed in healthcare promotional campaigns and medical programs involving lifestyle contracts. Thus, there is a clearly established acceptance of personal responsibility for health. While such contractarian perspectives are compelling, I will argue instead, that no patient is more entitled to care than any other, due to the numerous factors which impact an individual's

health, including income, education level, social and community support. Further, I will demonstrate that utilitarian perspectives indirectly assume individual responsibility and involve similar injustices to social contract theory-derived ones.

II. Attributions of Responsibility

Due to accumulating research and epidemiological evidence linking lifestyle factors to health and disease, health promoters and professionals have adopted the position that behavioral causes are major factors of *preventable* illness (Guttman and Ressler 118). This idea has been incorporated into healthcare promotional campaigns, which establish causal and moral connections between personal behaviors and subsequent health outcomes. By this reasoning, individuals who become ill are those who fail to maintain healthy lifestyles and prevent illness and are thus, morally responsible, and culpable for their conditions. Effectively, the ancient sins of gluttony, sloth, and lust have been replaced by the modern risk factors of overeating, failing to exercise regularly, and engaging in unprotected sex, which hold analogous moral implications for individual agents (Guttman and Ressler 118).

Related to assumptions of personal responsibility for one's own health imposed in public health address, physicians demonstrate agreement that responsibility should be used as a criterion for distinguishing between patients in the face of limited medical resources. In their 2021 study, Everett, et al. examine the sentiments of Norwegian and British doctors on the issue of including personal responsibility for illness in healthcare prioritization decisions. Study participants responded to three vignettes containing descriptions of hypothetical clinical scenarios in which resources are limited and only one patient can be helped. One such scenario posed: "Patient A is a life-long smoker. He grew up on a farm and all his family smoked. He has end-stage emphysema and requires a lung transplant to survive. He is currently smoking... Patient B is a non-smoker but has end-stage emphysema," (Everett, et al. 6). In each hypothetical clinical scenario, most doctors

from both countries answered that they would treat the relatively less responsible patient, or the patient whose lifestyle was not obviously connected to his or her illness (Everett, et al. 9). Thus, in the face of limited resources, physicians consider personal responsibility as a relevant criterion for treatment decisions.

Like the sentiments demonstrated by physicians, the lay public view personal responsibility as a relevant consideration for access to healthcare. Wittenberg, et al. presented survey participants with the hypothetical scenario of a liver transplant decision in which care can be allocated to only one of two patients. While one patient required a transplant due to an inherited factor, the other's liver failure was due to many years of heavy alcohol consumption (Wittenberg, et al. 203). Respondents who believed that those with alcohol-induced liver failure were personally responsible for their disease were more likely to allocate (hypothetical) transplants to the patient with the inherited factor, simultaneously refusing treatment to the alcoholic patient (Wittenberg, et al. 199). Thus, the idea that individuals are morally *culpable* for their illnesses follows the idea that individuals are causally responsible.

The discussed sentiments about personal responsibility for health have been relevant throughout the coronavirus pandemic. Responsibility has been attributed to several identified groups for the virus' proliferation, resulting in sentiments of blame. In the beginning of the pandemic, COVID-19's origin was pointed at the collective actor, 'the Chinese,' who were thought to be responsible for the spread of the virus due to their culinary habits which were characterized as primitive and uncleanly (Barreneche 20). The governor of Veneto, Italy publicly accused, "unlike Italians, the Chinese did not have good standards of hygiene and eat mice alive," (Ivic 424). As the virus was so widely distributed that the Chinese alone could not hold blame, the collective 'posh' were targeted for their vacationing habits which spread the virus across countries (Barreneche 21). Finally, the most widely encompassing group to which COVID- spreading is

attributed is the ‘irresponsible’ who prioritize their social lives over the well-being of the collective public, by attending social gatherings and refusing to wear masks (Barreneche 21).

III. Social Determinants of Health (SHD)

In recent decades, the public health community’s attention has been drawn to social factors as important determinants of individual health outcomes, somewhat diminishing the established role of medical care in shaping health (Braveman and Gottlieb 20). While health outcomes are largely influenced by behaviors, behaviors are strongly shaped by social factors, including income, education, and employment (Braveman and Gottlieb 20). A meta-analysis conducted by Galea, et al. revealed that the number of deaths in 2000 attributable to low education, racial segregation, and low social support were comparable to the number of deaths attributable to myocardial infarction, cerebrovascular disease, and lung cancer (1464). Further, there exists the general trend that health improves incrementally with social position (Braveman and Gottlieb 20). Thus, while there exists a widespread sentiment that individuals who engage in health-related risk behaviors should bear the costs and consequences, imposing responsibility for health onto individuals poses risks for worsening existing social inequalities.

Beyond general health disparities across socioeconomic statuses, there exist racial disparities in COVID-19 outcomes. Through the pandemic, Black, Asian, and minority ethnic groups (BAME) have emerged as more susceptible to higher morbidity and mortality rates than either US or UK white groups (Bentley 1). The CDC found that almost double the amount of Black and Hispanic individuals were hospitalized with COVID-19 than are proportionally represented in the community (Bentley 1). Importantly, social and structural differences predict these disparities rather than racial or genetic differences (Bentley 2). Social and structural inequalities which affect individual vulnerabilities include “exposures through types of employment, whether people are

working in essential transport networks carrying large numbers of people, or in small grocery stores,” (Bentley 2). Further, members of BAME communities are at heightened risk for metabolic disorders, including obesity, cardiovascular disease, all conditions linked to higher risk of COVID-19 contraction and poorer outcomes once contracted (Bentley 2).

In addition to disparities in susceptibility to COVID-19 and COVID-19 outcomes, there are disparities regarding vaccine hesitancy (Callaghan, et al. 2). Anti-vaccine advocacy groups, including the Children’s Health Defense have targeted African Americans with anti-vaccination messages, potentially contributing to these disparities (Callaghan, et al. 2). Such groups indicate that the COVID-19-vaccine perpetuates the historical pattern of medical abuses against Black Americans in the US, referencing the Tuskegee Syphilis Experiment (Callaghan, et al. 2). These messages promote peripheral trauma and potentially decrease the likelihood that minority groups will pursue vaccination (Callaghan, et al. 2). Affirming this risk, the National Health Interview Survey revealed that in years following the Tuskegee Syphilis Experiment, black men near the Tuskegee area reduced their interactions with outpatient physicians, resulting in a mortality increase (Alsan, et al. 325). In a national survey among Americans, Callaghan, et al. identify the least likely groups to vaccinate were women and Black Americans, with political conservatism also predicting negative intent (5). Importantly for the case of Black Americans, vaccination intentions are reflective of disparities in COVID-19 infection and mortality.

IV. Ethical Theories

While the COVID pandemic is novel and requires some context-specific considerations, there are several ethical perspectives which have been employed to determine the obligations held by physicians towards their patients. Before examining the ethical arguments applied specifically in the pandemic, it is important to understand the

underlying philosophical positions which have been applied across various medical contexts, namely utilitarianism and Rawls' social contract theory.

Given the established weight that individual responsibility holds in discussions of access to healthcare, social contract theory is a relevant perspective in the pandemic context. John Rawls presents the guiding idea for social contract theory as “the principles of justice for the basic structure of society are the object of the original agreement... that free and rational persons concerned to further their own interests would accept in an initial position of equality as defining the fundamental terms of their association,” (10). Through this reasoning, Rawls intertwines the concepts of justice and fairness and align both with the interests of individuals and the common good (12). As individuals benefit from being a part of their society, society benefits from having individuals avoid actions which harm the collective good. With these reciprocal benefits come reciprocal obligations; thus, under social contract theory consequences are warranted for those who fail to maintain their obligations to their society.

While Rawls' theory of justice was intended for the general structure of society rather than for a specific context such as healthcare, some guiding principles of the theory can be analogized to healthcare contexts. For example, Rawls outlines his principle of fairness by defining conditions which give rise to individual obligations (96). He considers an individual to be obligated to comply with a rule of an institution if, first, the institution itself is just. His second condition is that “one has voluntarily accepted the benefits of the arrangement or taken advantages of the opportunities it offers to further one's interests,” (96). For Rawls, individuals who derive benefits from a just institution can ‘fairly’ have their liberties restricted if such restriction yields widespread benefits through the system (96). When analogized to healthcare institutions, the sorts of liberties to be restricted are behaviors which pose health risks, such as smoking tobacco and living sedentary lifestyles. Thus, while Rawls' theory of justice applies to the general structure

of society, the guiding principles which entail individual obligations have been applied in healthcare contexts, to be discussed in the next section.

Another ethical perspective which holds relevance in the pandemic discussion is the consequentialist perspective of utilitarianism. The first notable utilitarian philosopher, Jeremy Bentham, articulates that ethical decisions should be made regarding the amount of pleasure which results, posing also that the number of individuals to whom pleasure or happiness applies must be considered when weighing decisions (Bentham 84). John Stuart Mill, in his *Utilitarianism*, presents the “Greatest Happiness Principle,” as the guide for ethical decisions: “actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness,” (10).

The general goal of utilitarianism as maximizing benefit for the greatest number of people provides some ambiguities which hold with regard to medical equipment and treatment during the pandemic. For instance, Mill furthers Bentham’s value for quantity of pleasure by providing that quality of pleasure must matter as well (Mill 11). He reasons that higher quality of pleasure can be found in only intelligent beings, whose experiences surpass those which can be attained by lower animals; thus, for Mill, the pleasures of intellectual discovery rank over the pleasures provided by eating something delicious (12). He explains that “few human creatures would consent to be changed into any of the lower animals,” and that, even amidst the heightened risks of suffering felt by rational beings, humans “can never really wish to sink into what he feels to be a lower grade of existence,” (2). This regard for quality of pleasure raises important considerations for utilitarian arguments in the pandemic, potentially presenting disadvantages for patients of low cognitive capacities related to disability or physical condition.

Both utilitarian and Rawls’ social contract theorist perspectives provide direction for navigating healthcare allocation decisions; however, both also entail issues

of inequity and inequality which deserve careful comparison and consideration. For instance, Mill's high regard for quality of pleasure may result in a de-prioritization of individuals with cognitive disabilities. Similarly, even if quality of life is dismissed, Mill's utilitarianism may result in other forms of discrimination. For instance, vulnerable groups may stand to benefit less from treatment than their healthier counterparts, given that chronic illnesses reduce life expectancy and therefore reduces the relative utility of a treatment (Savulescu, et al. 623). Similarly, social contract theorist perspectives imply ethical problems of blaming those who suffer from social inequalities which negative health outcomes (Steinbrook 755). While self-interested individuals should supposedly avoid risk-decisions which may harm their society and their own resources, those who reside in lower social positions do not enjoy the educational, structural, and monetary benefits which facilitate healthy behaviors.

V. Applied Theories in Healthcare Contexts

Prima facie, there seems to be a distinction of the role of personal responsibility across the two discussed perspectives, namely, Rawls' social contract theory directly implies that personal responsibility is a relevant criterion for medical resource allocation, while utilitarianism does not. Utilitarian perspectives appear to be 'fairer' in that they do not consider causes of illness or invoke blame to individuals. However, both perspectives result in the same moral pitfalls considering the inseparability of individuals, their social circumstances, and their health decisions and outcomes. Thus, the argument against employing personal responsibility as a criterion for medical resource allocation extends, not only to social contract perspectives, but also to utilitarian ones.

VI. Social Contract Theory in Healthcare

One example of how social contract theory may be applied in healthcare appears in the 2006 re-design of West Virginia's Medicaid program to incorporate personal responsibility as a qualifying factor for access to healthcare (Steinbrook 753). Under the

new plan, most low-income healthy adults and children received reduced basic benefits. However, by signing and adhering to the “Medicaid Member Agreement”, enhanced benefits could be obtained. These benefits include all mandatory services in addition to wellness-focused age-appropriate services, such as diabetes care, cardiac rehabilitation, tobacco-cessation programs, education in nutrition, chemical dependency, and mental health services (Steinbrook 754). There is a clear differentiation between the basic and enhanced plan and thus, a clear incentive to accept personal responsibility for health. For instance, while the basic plan only allots four prescription refills per month, the enhanced plan provides no limitations. To keep enhanced benefits, members must successfully comply with four responsibilities, including keeping medical appointments, receiving screenings, taking prescribed medications, and following health improvement plans (Steinbrook 754).

The Commissioner of the Bureau for Medical Services in the West Virginia Department of Health and Human Resources articulates the main goals of the program’s redesign, as “provid[ing] members with the opportunity and incentive to maintain and improve their health,” (Steinbrook 754). However, there are legitimate reasons for which members may not comply with enhanced plan conditions, including poor physician-patient communication, side effects of medication, impractical advice regarding job responsibilities, transportation, childcare, psychiatric illness, cost, complex recommendations, and language barriers prohibiting understanding of recommendations (Steinbrook 755). Further, the patients in most need of enhanced services, such as diabetes care, education in nutrition, and chemical-dependency and mental health services, may be those with the most difficulty complying.

Given that health related behaviors are significantly linked to social factors, including education, employment, and income (Braveman and Gottlieb 20), imposing responsibility for health onto individuals rather than social inequalities would not likely

improve health outcomes or modify health decisions. Thus, those with the most to gain from the enhanced services plan are likely to be those who are excluded from it. Despite the benevolent intentions of the plan, there is a risk for rewarding those with fewer needs for enhanced benefits and marginalizing those who are most vulnerable

Some less explicitly social contract theorist positions have been incorporated in healthcare discussions, though they result in the same risks to equity and equality as does the WV Medicaid program re-design. For instance, Alena Buyx argues that personal responsibility can ethically be used as a criterion for rationing decisions, proposing liberal egalitarianism to reconcile the negative associations with responsibility-based resource allocation, such as libertarian perspectives. For instance, libertarian healthcare proponents argue that individuals have the right to decide on how to spend their funds according to their life plans and reject any mandatory redistribution of personal funds to social programs (Buyx 871). However, as Buyx points out, under such a healthcare system, large portions of the population would be left without public support in cases of illness (872). Conversely, proponents of communitarian theories of justice argue that the common good outweighs the importance of individual preferences (Buyx 871). Thus, preventative and rehabilitative treatment for the public should replace expensive treatments for the few in the pursuit of a healthier population. However, individuals who become ill despite preventative and rehabilitative efforts would be considered burdensome to the common good due to their need for expensive treatment (Buyx 872).

As an alternative, Buyx proposes liberal egalitarianism which balances the needs and preferences of individuals with the need to support societal institutions to the end of protecting equality of opportunity (Buyx 872). This perspective encompasses the principle of solidarity, a sense of togetherness between the members of a society. Togetherness, in this context, entails being part of a system deemed precious and important and therefore, requiring members to support it and actively attempt to avoid

harming the system (Buyx 872). Thus, a liberal egalitarianist medical system would require its members to act responsibly regarding their health. However, to avoid the discussed consequences of libertarian and communitarian healthcare systems, Buyx proposes that personal responsibility only serve as one criterion among many in a matrix used for care allocation (873). Additionally, she maintains that even in cases of personal responsibility for illness, baseline healthcare provisions are necessary (872). Finally, she proposes that incentives should be offered for those who engage in programs designed to combat problematic health behaviors such as smoking, sedentary lifestyles, or bad diets.

Finally, Buyx acknowledges that if personal responsibility were to be employed as a criterion for healthcare access, efforts would have to be made to change the “toxic environment” and diminish social impact on health behavior (873). For a person to retain responsibility for herself, she must possess adequate knowledge and health literacy to make informed decisions. Thus, improving widespread education about health maintenance are necessary before personal responsibility can ethically be employed to make treatment allocation decisions. Further, Buyx acknowledges the problem of social stratification of health behaviors, which could be worsened if personal responsibility were to be incorporated into healthcare access decisions, by imposing burdens onto already vulnerable groups (874). Despite the problems attached to imposing personal responsibility, Buyx’s final resolve is that personal responsibility will likely improve health and therefore ought to be placed as a consideration in healthcare access.

While Buyx paints a hopeful image of a healthier society, current social conditions and health disparities prevent any ethical implementation of such a program. For instance, Andreas Albersten presents the criticism to liberal egalitarianism that it is “not sufficiently attentive to the complex relationships between social circumstance and health outcomes,” (564). Albersten demonstrates that the metaphysical debates about causation and responsibility are inevitable components of the healthcare discussion, as

many behaviors are contingent on social determinants in health, including where people live, whether they are employed, and their general socio-economic positions. Thus, imposing personal responsibility cannot be equitable or fair due to the stratifications in social conditions which impact behavior and subsequent health outcomes.

VII. Utilitarianism in Healthcare

During the initial months of the pandemic, the threat of medical resource exhaustion grew. As the number of patients in critical condition exceeded the number of ventilators and ICU beds available, healthcare providers were forced to choose to treat some patients and not others. However, the US Department of Health and Human Services promised that “persons with disabilities, limited English-speaking skills, or needing religious accommodations should not be put at the end of the line for health services during emergencies. Our civil rights laws protect the equal dignity of every human life from ruthless utilitarianism,” (Savulescu, et al. 620). Utilitarianism as a moral theory is often criticized as a ruthless theory which reduces individuals to their utility and therefore uses them as means to certain ends (Savulescu, et el. 621). However, despite some of the associations with the ethical theory, the scope of the pandemic necessarily places many lives at stake and presents difficulties in justifying focusing on individual-rather than population-level benefit.

In their comparative analysis of the national and international triage policies designed for the pandemic, Susanne Jobges, et al. determine utilitarianism to be the prominent ethical perspective worldwide (949). However, the goal of maximizing benefit does not afford clear criteria which can be employed to distinguish between patient prospects. For instance, maximizing benefit could entail maximizing the number of lives, regardless of prognosis, comorbidities, or age (Jobges, et al. 949). Conversely, it could entail maximizing the number of life years saved, which would privilege those with stronger survival prospects and greater life expectancies. Further, maximizing benefit

could mean focusing on quality-adjusted life years, which favor those with a capacity to live long, independent lives. This may necessarily incorporate some forms of discrimination towards those with cognitive or physical impairments, as impairments could limit the kinds of benefits that can be enjoyed after treatment (Jobges, et al. 957). Maximizing benefit also necessitates considerations for those of “instrumental value,” such as healthcare workers who endanger their own lives while potentially saving many others. While some of these distinct kinds of benefit maximization may be combined, some choices are necessarily mutually exclusive. For instance, comparing a young patient with a severe cognitive impairment but otherwise good health and a much older patient with no cognitive impairments, either quality-adjusted life years saved, or mere quantity of life years saved must be chosen as a basis for prioritization.

Whichever conception of benefit maximization is accepted, there are necessary ethical implications which follow. For instance, if maximizing benefit is interpreted to mean maximizing the number of lives, regardless of prognosis, comorbidities, or age, the result could be a massive preventable loss of life (Savulescu, et al. 620). Employing such a blind method of treatment prioritization would likely entail that individuals with low survival chances are treated in favor of those with many life years to gain, a consequence which would be difficult to justify under the mere premise of equal and equitable access to treatment. Using this blind method would likely result in the loss of lives which could have been prevented if patient health conditions and survival chances were considered. However, if the decision-making aim becomes maximizing the number of life years saved, there necessarily arise issues of inequity and inequality associated with health disparities across socioeconomic conditions.

Given the nature of decisions which must be made during crises such as the pandemic, Salvulescu, et al. first consider some of the utilitarian ‘rules-of-thumb’ employed (623). The dominating rule for utilitarians is number; thus, when allocating

medical resources, the aim should be to maximize the number of lives saved (Savulescu, et al. 623). Salvulescu, et al. propose several triage scenarios and derive several sub-rules-of-thumb which support maximizing benefit across numbers. First, they consider a patient with a 90% survival chance with another who has only a 10% survival chance. In this case, the clear intuitive utilitarian position favors the patient with a higher likelihood of survival, given that treating the riskier patient may result in two lives lost (623). Savulescu, et al. also consider the importance of resources in weighing such triage decisions. For instance, if one patient will likely require ventilator treatment for four weeks, while the other would likely benefit after only one week, there is a utilitarian basis for treating the latter patient and making the ventilator available for others in need, since this will result in more lives saved (623)

Another important criterion which comes into play in triage decisions aimed at utilitarian outcomes is life expectancy (Savulescu, et al. 623). The end of maximizing benefits is impacted more by individuals whose lives are saved by longer rather than shorter periods of time. Thus, utilitarian principles tend to favor the young in triage decisions; though if a younger person held a lower life expectancy due to some non-age-related factor, the opposite decision would be justified. While age, in many cases, is tied to life expectancy, Savulescu, et al. maintain that this criterion is not an explicit form of ageism because the length of the benefit is the justification for such choices.

Beyond simply quantities of lives and life years, utilitarians also consider quality of life. While this poses concerns for protections of vulnerable groups, such as those with cognitive or physical disabilities, the goal of benefit maximization necessarily entails regard for life quality. To exemplify this reasoning, Savulescu, et al. propose a treatment decision between a patient who works full time and possesses all his mental faculties and a patient whose end stage dementia predicts that she will be rendered unconscious soon (623). While both patients would likely survive the treatment and

probably stay *alive* for comparable amounts of time, it would be difficult to make the case that both patients would derive the same benefit from the treatment. Further, it would probably be equally difficult to argue that the precious medical resources would be best spent on the cognitively impaired patient.

Savulescu, et al. further point out that utilitarianism is often in direct conflict with the principle of responsibility in healthcare decisions (625). This is because for utilitarians, intentions do not matter. Utilitarians reject “all direct consideration of causal contribution to illness, and indeed, any backward-looking considerations,” (625). Thus, though personal responsibility may pose concern for an individual whose lifestyle of overeating caused diabetes, for utilitarians, it is only relevant as it impacts survival likelihood and life expectancy. While using medical criteria in resource allocation decisions may satisfy utilitarian goals of maximizing quality life years saved, doing so necessarily implies personal responsibility for health.

VIII. Conclusion

Considering the two applied ethical perspectives aimed at justice and fairness in healthcare—namely, social contract theory and utilitarianism—, there arise disquieting implications regarding social inequalities. Healthcare conceptions of Rawls’ social contract theory directly attribute personal responsibility for health to individuals, making healthcare availability reflective of the risks associated with their lifestyle factors. While this sort of system seems to empower individuals with the ability to determine their healthcare options, empirical evidence suggests that behavioral factors are highly associated with socio-economic factors. Thus, social contract theory- derived healthcare systems pose the ethical risk of blaming individuals for the social inequalities they are suffering from.

Utilitarian perspectives focus on medical criteria rather than personal lifestyle considerations, thus providing a more objective way of allocating healthcare. Under these

guidelines, patients are evaluated in terms of the benefits they may derive from medical treatment compared to other patients in need. While this seems to eliminate the victim-blaming problem of social contract systems, utilitarian guidelines result in the same disfavoring of the already-vulnerable. The same end is met whether a patient is denied access to a ventilator because he smoked cigarettes for fifty years or because his lung disease worsens his life expectancy compared to other patients. The implications of socio-economic factors on individual lifestyles are similar to their implications on health factors, such as metabolic disorders, obesity, and cardiovascular diseases, all comorbidities associated with negative outcomes with COVID-19.

The reviewed social scientific literature presents a bleak, deterministic model which related individuals to their social circumstances, lifestyles, and health outcomes. Whether through Rawlsian social contract theory or utilitarianism, the ‘fair’ and the ‘just’ allocation of resources only pose benefits for the privileged. Thus, there arises the need to allocate resources in ways that favor the most vulnerable members of social systems. Given the drastic social inequalities which persist through COVID-19 outcomes, ethicists have proposed that those who are ‘most unfairly exposed to SARS2, such as poorly paid workers in nursing homes... [or] prisoners or undocumented workers held in crowded detention centers,’ (Pence 83). This sort of resource allocation would work against social inequities and inequalities, potentially diminishing the health disparities that exist across racial, ethnic, and economic lines.

Another way that healthcare allocation could be used to work against inequalities is shown in a New York policy that allows nonwhite race or Hispanic ethnicity to be a consideration when dispensing anti-viral treatments which are limited in supply (Woodward and Klepper 1). This policy is aimed at steering treatments to those who at the most risk of severe disease from coronavirus, citing that “long-standing health and social inequalities make people of color more likely to get severely ill or die from the

virus,” (Woodward and Klepper 1). Such policies could also be implemented with respect to disparities outside of COVID-19 outcomes, providing priority for surgery or organ donation for those whose socio-economic factors place them at risk for negative health outcomes.

Though both utilitarianism and Rawls’ social contract theory both attempt to provide justice and fairness in the face of limited medical resources, both fall short due to existing health disparities and social inequalities. While the principles of each theory may be ethically acceptable in a world of widespread social equality, neither can be used while such injustices persist. Thus, healthcare allocation must be aimed at helping the most vulnerable groups in society until their social circumstances no longer pose such bleak implications for their health.

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