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The Conflict Between Distributive Justice and Ageism in Public Health Emergency of International Concern in the UK During the COVID-19 Pandemic

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Abstract. During the COVID-19 pandemic, shortages of intensive medical resources have occurred worldwide. This shortage affects the distribution criteria and may lead to ageism. In this paper, we discuss the intersection of ageism and distributive justice in the UK ICU triage, which serves as our primary focus. Our research is based on the National Institute for Health and Care Excellence (NICE) guideline NG159 and its use of the Clinical Frailty Scale (CFS). We explored the concept of ageism and explained why prioritizing access to scarce ICU resources was an important issue during the pandemic. Through a case study, we analyzed the specific UK situation and discussed the potential criticisms that it showed indirect age bias and discrimination. A comparison was made with the approaches in Germany and New Zealand, showing alternative ways of triage. We then conclude ethical lessons for future emergency planning by synthesizing the solutions from the three countries.

Keywords: Ageism, Distributive Justice, Bioethics, COVID-19 Pandemic

1. Introduction

Ageism is the prejudice and discrimination based on age. Ageism is a big problem, as half the world population is ageist against older people [1]. Bias like this would influence the distributive justice of social resources. In the context of bioethics, distributive justice primarily focuses on the allocation of scarce healthcare resources. The emergency events undoubtedly maximized this conflict. During the COVID-19 pandemic, the health systems were overwhelmed as the number of patients increased daily, while resources were limited. The problem of ageism became more serious under this background when older people were disproportionately affected by the virus, and the resources were scarce. The approaches for different countries to deal with the medical resources' shortages caused by the COVID-19 pandemic have uncovered how widespread ageism is when older and younger people have been stereotyped in triage. In some contexts, age has been used as the only criterion for making cutoffs for access to medical care. In this context, distributive justice in bioethics refers to the principles that guide the fair allocation of scarce healthcare resources. Questions about distributive justice arise when not everyone has an equal opportunity to receive saving treatment. The UK government published the NICE guideline NG159, an ICU triage guideline, in March 2020

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to support healthcare systems in allocating limited resources. In our study, we used this guideline as a case study to examine its underlying principle and aftereffects. Additionally, we will compare this approach with those of other countries to reach a definitive conclusion and provide some suggestions for further development.

2. Theoretical framework

The two main ethical frameworks that build up distributive justice are utilitarianism and egalitarianism. Utilitarianism is the approach that take the overall good as the most important, that is, in the medical context, saving as many people as possible. It is a consequential theory: only the results of actions matter. There may cause problems like doctors weighing the lives of the younger people as more valuable as they can have a longer life-year in order to save more lives overall. This approach is therefore more focused on efficiency. In a triage situation, available resources are distributed as efficiently as possible. Consequently, utilitarian ideals are inbuilt into the very concept of triage. Many of the analyzed guidelines propose allocating health care in a way that maximizes the total number of lives saved [2]. On the other hand, egalitarianism focuses more on equality. Every person has an equal opportunity to get a particular resource. However, it is natural for the triage to place certain people over others, no matter it is in the medical context or other situations. While utilitarians prefer maximization of the outcome to equal opportunity for every one to get the medical care, egalitarians hold the other view that when the two goals of saving the most people and pursuing equity conflict, they prefer to let everyone receives an equal opportunity even at the cost of it may leads to a lower overall utility. For instance, some ethicists argue in favor of prioritizing younger patients on utilitarian grounds, while others argue that "age should never be a sole criterion" for life-saving treatment. The question is urgent because COVID-19 starkly highlighted age as a risk factor. Triage and vaccination policies were widely justified in terms of "maximizing benefit," which may include prioritizing younger or less frail patients to save more life-years. For example, some argued that the pandemic was an older people's problem that was best managed by socially isolating them, rather than the entire population, because older people "already have lived their lives and now it is time for them to step down" [3]. This illustrated the stakes: the very lives of grandparents, parents, and vulnerable elders were at issue.

3. Case study

The BMA COVID-19 Ethics Guidance offers a comprehensive overview of ethical considerations in healthcare during the pandemic. The purpose is to guide healthcare professionals in making critical decisions regarding resource allocation, the decision of whether giving treatment, discrimination in prioritization decisions, maintaining essential services, management of risk, the impact on the society, the importance of fair process, and liability issues. The guidance advocates for the prioritization of patients based on clinical need and the likelihood of benefit, but acknowledges the challenge of resource scarcity in a public health crisis. Conclusions emphasize that ethical decision-making must be dynamic, transparent, and informed by evolving public health evidence. The guidance calls for continuous reflection on ethical principles as the crisis unfolds. It addresses concerns about potential discrimination when patients are denied access to life-saving treatments due to triage or prioritization decisions. It acknowledges that during the peak of a pandemic, decisions based on a patient's capacity to benefit quickly may disproportionately affect older individuals and those with long-term health conditions. The data about COVID-19 from the beginning of the pandemic shows a strong correlation between older age and mortality. Although

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work has not been done yet to establish whether this reflects an actual effect of age or simply a correlation between age and comorbidities that will affect survival rates, it is likely that the most challenging triage decisions will be made for these groups [4]. The guidance emphasizes that such decisions must be grounded in clinical factors related to outcomes, avoiding discriminatory judgments based on age. It explicitly states that policies should not include arbitrary age or disability cut-offs, as these would be both unethical and unlawful. NICE explicitly stated that instead of making decisions based on age, it proposes triage based on frailty for decisions regarding level of care". In principle, this shift aimed to prevent crude age discrimination. The CFS ranks patients from "very fit" (1) to "terminally ill" (9) based on their recent functional status. In an early draft, NICE provided a simple algorithm: patients over 65 and with CFS ≥5 (moderately frail or worse) would be directed to ward-level care rather than ICU, with younger or less frail patients potentially admitted [5]. However, this frailty-based scheme quickly drew criticism as it seems to show ageism in disguise. Since the CFS was validated only in patients over 65, applying it to younger patients or to those with lifelong disabilities was questioned. Early reports noted that the NICE flow-chart explicitly included an "age 65 or over" branch alongside "CFS >5," which appeared to make age a factor. Subsequently, NICE has revised the guideline several times to make clear that CFS scores should not be used in any patient aged under 65 or in any patient with a stable long-term disability [6]. This case shows that triage making is a complex work which may be seen as a hidden bias against older people. The UK policy employed both utilitarian and egalitarian approaches, aiming to strike a balance and avoid misconceptions.

4. Comparison

In comparison to the UK approach, Germany's triage guidelines focused more on the likelihood of survival rather than making any age cutoff. Germany aimed to ensure that as many patients as possible could benefit from medical care [7]. Moreover, in late 2021, the German government announced a new rule that requires the protection of people with disabilities. Germany's highest court has established rules to protect people with disabilities. Although it primarily focused on people with disabilities, it reflected the attitude towards vulnerable groups and demonstrated a commitment to egalitarianism. Thus, unlike the UK, Germany's stance was that triage cannot rely solely on categorical age separation but must also be consistent with egalitarian principles.

In the New Zealand context, the New Zealand National Ethics Advisory Committee(NEAC) mentions that "disability status or age must not be used as a simple proxy for health status or capacity to benefit. Screening measures, including the quality-adjusted life year (QALY) measure, must be avoided, as they are inherently biased against people with disabilities. Triage decisions should be based on assessment of an individual's personal medical history." [8] The screening measures in New Zealand prioritize equity and strive to minimize potential discrimination. This reflects a mixed stance, as NEAC accepts the need to consider medical benefits but rejects any shortcut rule that disadvantages the entire demographic. It aimed to maximize benefits without endorsing age cutoffs.

Therefore, in both the German and New Zealand contexts, they take equity more seriously and fight against possible discrimination than in the UK. These comparisons demonstrate that alternative guidelines exist, and each country has its own unique cultural values that lead to a different solution to deal with the problem.

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5. Discussion & conclusion

The NICE guideline was formulated to avoid arbitrary age cut-offs, but it also reveals a preference for utilitarian efficiency. Policymakers aimed to save the largest number of patients. This caused possible discrimination towards people with disabilities and the elderly. Therefore, the final policy made some changes and tried to be a compromise between utilitarianism and egalitarianism. However, the policy and the practice could be quite different. The oldest groups were rarely admitted to an ICU for healthcare. There was still room for improvement in reaching the ultimate balance of equity and efficiency. The UK experience shows that clinical judgments need to be constantly scrutinized to ensure it does not conceal bias. The German example shows that legal protection can check utilitarian excess, and the New Zealand example suggests respecting all ages equally. These examples provide us with several valuable ethical lessons. First, ageism must be guarded against, regardless of the situation. Second, distributive justice should consider both efficiency and equity. The two approaches must be weighed. Third, global comparisons can introduce new ideas to the country and enhance its development. A combination of the triage protocols will be beneficial.

In practice, we recommend that future emergency planning efforts strive to avoid discrimination and that triage protocols be developed in consultation with broader stakeholders. The frontline staff should be taught ethical lessons so that the practice can be consistent with the policies. Additionally, it is crucial to inform society that while saving as many lives as possible is essential, upholding respect and advocating for equity across all ages is also a vital component of distributive justice.

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