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Résumé de l'article

Avant la pandémie de COVID-19 (ci-après « la pandémie »), l'adéquation des ressources en matière de soins de santé dans l'ensemble du Canada suscitait déjà de nombreuses inquiétudes. La pandémie de COVID-19 a exacerbé ces inquiétudes de manière exponentielle, en élargissant les fissures déjà importantes dans les systèmes de santé provinciaux. Actuellement, le système est confronté à l'exacerbation des délais d'attente pour les opérations chirurgicales qui avaient été retardées par les fermetures obligatoires pendant la pandémie. En Ontario, les retards dans les opérations chirurgicales et les retards associés en radiologie et dans d'autres services essentiels aux soins pédiatriques ont conduit à la création d'un consortium d'hôpitaux pédiatriques qui se sont engagés à plaider en faveur d'un financement accru de la pédiatrie. Jusqu'à présent, les gouvernements provinciaux et fédéral ont accepté une injection ponctuelle de fonds, mais le consortium demande une augmentation permanente du financement de la pédiatrie. Le secteur des adultes a également souffert de retards et d'arriérés. En outre, comme nous l'avons déjà noté, les adultes plus âgés ont supporté le poids de la morbidité et de la mortalité associées au COVID-19. Le défi pour le secteur pédiatrique est de savoir si et comment défendre la priorité accordée aux enfants et aux jeunes. Dans cet article, nous passons en revue quatre approches de l'allocation équitable – l'âgisme utilitaire, des manches équitables (*fair innings*), l'approche prudentielle de la durée de vie et l'âgisme prioritaire – et examinons leurs forces et leurs faiblesses. Nous concluons en soutenant l'âgisme prioritaire (prioritarisme). Le prioritarisme conserve les points forts de l'âgisme utilitariste et des manches équitables tout en évitant leurs faiblesses. En outre, comme le prioritarisme ne considère pas l'âge comme un critère moral indépendant, les systèmes d'attribution fondés sur cette base sont moins susceptibles de faire l'objet de contestations juridiques et peuvent être plus acceptables pour le grand public.

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The Elephant in the Nursery: Paediatric Exceptionalism?

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Résumé
Avant la pandémie de COVID-19 (ci-après « la pandémie »), l'adéquation des ressources en matière de soins de santé dans l'ensemble du Canada suscitait déjà de nombreuses inquiétudes. La pandémie de COVID-19 a exacerbé ces inquiétudes de manière exponentielle, en élargissant les fissures déjà importantes dans les systèmes de santé provinciaux. Actuellement, le système est confronté à l'exacerbation des délais d'attente pour les opérations chirurgicales qui avaient été retardées par les fermetures obligatoires pendant la pandémie. En Ontario, les retards dans les opérations chirurgicales et les retards associés en radiologie et dans d'autres services essentiels aux soins pédiatriques ont conduit à la création d'un consortium d'hôpitaux pédiatriques qui se sont engagés à plaider en faveur d'un financement accru de la pédiatrie. Jusqu'à présent, les gouvernements provinciaux et fédéral ont accepté une injection ponctuelle de fonds, mais le consortium demande une augmentation permanente du financement de la pédiatrie. Le secteur des adultes a également souffert de retards et d'arriérés. En outre, comme nous l'avons déjà noté, les adultes plus âgés ont supporté le poids de la morbidité et de la mortalité associées au COVID-19. Le défi pour le secteur pédiatrique est de savoir si et comment défendre la priorité accordée aux enfants et aux jeunes. Dans cet article, nous passons en revue quatre approches de l'allocation équitable – l'âgisme utilitaire, des manches équitables (*fair innings*), l'approche prudentielle de la durée de vie et l'âgisme prioritaire – et examinons leurs forces et leurs faiblesses. Nous concluons en soutenant l'âgisme prioritaire (prioritarisme). Le prioritarisme conserve les points forts de l'âgisme utilitariste et des manches équitables tout en évitant leurs faiblesses. En outre, comme le prioritarisme ne considère pas l'âge comme un critère moral indépendant, les systèmes d'attribution fondés sur cette base sont moins susceptibles de faire l'objet de contestations juridiques et peuvent être plus acceptables pour le grand public.

Mots-clés
pédiatrie, enfants, priorité, allocation des ressources, éthique

Abstract
Prior to the COVID-19 pandemic (hereafter, 'the pandemic'), there was already widespread concern about the adequacy of health care resources across Canada. The COVID-19 pandemic exacerbated these concerns exponentially, widening already significant cracks in provincial health care systems. Currently the system is struggling with the exacerbation of wait times for surgeries previously delayed by mandated closures during the pandemic. In Ontario, the backlog of surgeries, and associated backlogs in radiology and other services critical to paediatric care, led to the creation of a consortium of paediatric hospitals committed to advocacy for more funding for paediatrics. Thus far, the provincial and federal governments have agreed to a one-time cash infusion, but the consortium is calling for a permanent increase in funding for paediatrics. A challenge is that the adult sector has also suffered from delays and backlogs. Furthermore, as already noted, older adults have borne the brunt of morbidity and mortality associated with COVID-19. The challenge for the paediatric sector is whether and how to defend the prioritization of children and youth. In this paper, we review four approaches to just allocation – utilitarian ageism, fair innings, the prudential lifespan approach, and prioritarian ageism – and examine their strengths and weaknesses. We conclude by endorsing prioritarian ageism (prioritarianism). Prioritarianism retains the strengths of utilitarian ageism and fair innings while avoiding their weaknesses. Furthermore, because prioritarianism does not treat age as an independent moral criterion, allocation schemes based on this foundation are less susceptible to legal challenge and may be more palatable to the general public.

Keywords
paediatrics, children, priority, resource allocation, ethics

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INTRODUCTION

In this paper we examine moral arguments that support what we will call "paediatric exceptionalism", that is, the view that children and youth should be prioritized in the allocation of health resources. Our goal is to determine whether paediatric exceptionalism can be justified in a society like Canada, one that is firmly committed to rights and non-discrimination as instantiated in the Charter of Rights and Freedoms and provincial Codes of Human Rights. We explore this question using the current surgical backlog as a springboard, beginning with a high-level description of the backlog to highlight the challenges in both the adult and paediatric sectors. We then review four approaches to just allocation – utilitarian ageism, fair innings, the prudential lifespan approach, and prioritarian ageism – and examine their strengths and weaknesses, and conclude by endorsing prioritarian ageism (prioritarianism). Prioritarianism, we argue, retains the strengths of utilitarian ageism and fair innings while avoiding their weaknesses. Furthermore, because prioritarianism does not treat age as an independent moral

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criterion, allocation schemes based on this foundation are less susceptible to legal challenge and may be more palatable to the general public and/or governments.

BACKGROUND

During the first wave of the pandemic, elective “non-urgent” surgeries were stopped as a public health measure, to control the spread of COVID-19 and ensure that adequate ICU resources were available for the treatment of infected individuals; only urgent cases were allowed to continue. While surgical waitlists were a challenge before COVID – e.g., data from 2018 shows that only 65% of elective surgeries in Canadian children’s hospitals were completed “within window” – this strategy has resulted in vastly longer waitlists in both the adult and paediatric sectors (1). In 2022, the Ontario Medical Association called for increased funding to clear a pandemic backlog of medical procedures of almost 22 million health care services, including one million surgeries (2). About 12,000 of these surgical cases involve children, and about half of these children are waiting beyond clinically recommended wait times (3).

Wiebe et al. (4) note that two types of cases have been significantly affected: avoidably urgent cases and quality of life cases. Avoidably urgent cases are not yet urgent enough to warrant treatment but will eventually become urgent if they are not addressed. Quality of life cases may never escalate to an ‘urgent’ classification, but the consequences of delay are persistent and significantly compromise quality of life related, for example, to development, mobility, fertility or mental health (4).

It is crucial to underscore how serious these sequalae may be even though the surgeries in question do not address ‘urgent’ needs. For example, a Canadian study of adults diagnosed with cancer between September 2015 and 2020 found that delays in cancer detection associated with the shut-down led to advanced disease at presentation, and more unresectable, incurable cancers (5). Another study, published in 2020, modelled the impact of deferred joint replacement surgery, concluding that while moderate delays may not impact the severity of osteoarthritis itself, these delays can lead to a wide range of downstream negative effects including muscle wasting due to immobility, decreased quality of life, depression, and susceptibility to substance abuse disorders including opioids, alcohol, prescription and illegal drugs (6).

Data concerning the impact of delays on the paediatric population are harder to come by, but the relevant effects clearly overlap with those in the adult sector. Children, too, suffer from cancer and the harms associated with delayed cancer detection and treatment. Children and youth also suffer from decreased quality of life, depression and susceptibility to substance abuse and other mental health disorders. In addition to these, however, are the lifelong effects of delayed interventions. Out of window surgeries can have life-long consequences due to their relationship to and causal effect on the growth and development of children and youth requiring surgery that is delayed (7). Prioritizing urgent cases over elective cases for several weeks has minimal consequence for those in the “non-urgent” group. However, when sustained over months and years – the situation in which we are now – the cumulative burden to these patients becomes overwhelming (8).

In Ontario, the backlog of surgeries, and associated backlogs in radiology and other services critical to paediatric care, led to the creation of the Children’s Health Coalition (the Coalition), a provincial group that includes paediatric hospital and children’s health organizations. The Coalition launched a campaign calling for “a concerted, long-term plan to address kids’ health with an investment of 1 billion over four years.” (9) So far, the Federal government has provided the provinces with a one-time 2 billion dollar cash infusion to use as they see fit, but it was not initially clear where those funds would go. Prior to this year’s provincial budget, the Coalition asked the Ontario government for $371 million a year for the next four years to address the backlog. The budget did include a one-time infusion of $200 million to help address the backlog in paediatric care, but the consortium is calling for a permanent increase in funding for paediatrics. “We need a permanent infusion of funds for surgeries, we can’t just go year to year… You can’t hire staff with one-time dollars.” (3)

An important challenge is that the adult sector also endured mandatory suspension of elective surgeries during the pandemic, and adult patients also face unprecedented wait times for surgery. Furthermore, adults have borne the brunt of morbidity and mortality associated with COVID-19. How, in this context, can we justify prioritizing the young? Assuming resources are finite, and given more funding to some means less for others, what distribution is fair? Is prioritizing the young ethically justified?

Fundamentally, these are questions of justice. The challenge for the paediatric sector – in which two of us work – is whether it is justifiable to prioritize the young and, if so, how to defend this policy. For the purposes of this paper, we use the phrase “paediatric exceptionalism” to refer to the prioritization of children and youth. Our central question is this: is paediatric exceptionalism ethically justified? We will explore this question using the surgical backlog in both (paediatric and adult) sectors as a springboard. Beginning with a review of four approaches to just allocation that have received the most attention in the associated literature (10), we consider whether these approaches can be used to support paediatric exceptionalism and examine their strengths and weaknesses.

It is important to first acknowledge that the COVD-19 pandemic, though difficult for almost everyone, disproportionately affected racialized, marginalized and equity deserving groups. The same can be said about the surgical backlog. It is also true that mainstream theories of justice, like those we will examine below, have often failed to explicitly acknowledge or account for racism, colonialism, and other systemic or structural inequities that have characterized much of “the modern world” since the 1500s. Some commentators have thus called for the wholesale rejection of mainstream theories of justice, arguing that they are inherently – not just accidentally – connected to colonialism and its racist underpinnings. Others have responded in a different way, namely by arguing that the best way to achieve justice for all is to enlarge or modify these

mainstream (e.g., liberal) accounts of justice (11). Key improvements are an inclusive account of membership in the moral community (e.g., the inclusion of women and racialized people) and recognition of the harms associated with structural inequality.

For the purposes of our current project, we examine whether four mainstream theories of justice provide support for paediatric exceptionalism in accordance with the latter view; that is, we assume that these theories are not inherently connected to colonialism or racism and can be modified to support justice within a society committed to human rights and non-discrimination.

ETHICAL ARGUMENTS

To assess whether and/or when paediatric exceptionalism may be morally defensible, we require an account of just allocation. There are many such accounts, but in the rest of this section we review four common approaches to just allocation: *utilitarian ageism*, *fair innings*, the *prudential lifespan approach*, and *prioritarian ageism*. First, we discuss whether and to what extent each approach supports paediatric exceptionalism, and then discuss possible objections against each approach. Before turning to this task, however, it is useful to review some key distinctions introduced by Greg Bognar (10).

In his 2016 book chapter “Priority Setting and Age”, Bognar notes that considerations related to age play a pervasive role in both health policy and clinical practice. At the policy level, for example, age frequently influences cost-effectiveness studies and disease burden estimates. Age is also frequently used in clinical practice as an indicator for the risk of contracting a disease, and as a factor with respect to the risk of adverse events or the probability of benefits from treatment (10). He notes, however, that this role may be direct or indirect. In the context of the moral justification of resource allocation, age plays a direct role when it provides an independent moral justification for a given allocation. In indirect views, by contrast, age is merely an indicator or proxy for other factors deemed morally relevant. In such views, age may be used as a criterion for decision making, but it is not used as a criterion for moral justification (10).

Another perhaps more familiar distinction that will be useful for present purposes is that between consequentialist approaches to just allocation, and fairness-based approaches. In general, consequentialist approaches focus on maximizing ‘good’ consequences overall. Fairness based approaches, by contrast, are concerned with the distribution of benefits across individuals or groups instead of, or in addition to, their maximization overall. Using these two distinctions, we can categorize the four views to be canvassed below as follows (see Table 1):

Table 1: Categorization of Allocation Approaches

	Consequentialist	**Fairness-based**
Direct role for age	n/a	Fair Innings
Indirect role for age	Utilitarian Ageism Prioritarian Ageism*	Prudential Lifespan Approach

* Though Prioritarian Ageism is a consequentialist view, it does incorporate distributional commitments to fairness reflected in the age-based weighting of life years. Prioritarianism could thus arguably be considered a fairness-based view as well.

Utilitarian Ageism

Consequentialist approaches to allocation focus on maximizing benefits overall. Simply put, such approaches to allocation are concerned with maximizing the impact of a given resource. Since Canada – like most of the middle-upper income countries – is now experiencing an extended period of weak economic growth coupled with burgeoning debt associated with the pandemic, consequentialist considerations of this sort may be particularly relevant to policy makers at this time.

To provide meaningful guidance, consequentialist approaches must settle on a theory of value: What ‘good’ are we seeking to maximize? What ‘bad’ are we seeking to minimize? Utilitarianism is probably the best-known form of (moral) consequentialism. Classical utilitarianism deployed a hedonistic theory of value according to which happiness or well-being is good, suffering is bad. For classical utilitarians, the right decision or policy is that which maximizes happiness or well-being (and minimizes suffering) overall, everyone considered equally. Faced with the current surgical backlog, how would a (classical) utilitarian approach our central question? Is paediatric exceptionalism justified from a utilitarian point of view?

First of all, younger people typically have more years to live post-surgery. Given that the current surgical backlog involves conditions that are not lethal, the costs of missed surgery are chronic deficits, disability and other long-term sequelae. In the case of young people, as we saw above, there is significant concern about the developmental impacts of delayed surgery, harms that may follow children for the rest of their lives, with associated life-long costs for them, their families and the health care system. Finally, surgery on adults, particularly older adults, is often riskier and outcomes poorer. For these reasons, prioritizing the younger over the older may be justified on benefit-maximizing grounds.

This view is sometimes called utilitarian ageism (10), but the term is misleading as utilitarian ageism is not really concerned with age per se. Instead, age is used as an indicator of life expectancy: younger people typically have more years left to live than older people. Life expectancy, in turn, is only of relevance from a utilitarian point of view insofar as it is correlated with expected well-being. From the perspective of utilitarian ageism, in sum, age is a rough indicator of expected well-being; it does not play a direct role in the moral justification of allocation (10).

Assessing utilitarian ageism

Unfortunately for utilitarian ageism, critics can point to the many problems it inherits from utilitarianism more generally. Consider the insensitivity to the distribution of benefits. As noted above, utilitarianism concerns itself with maximizing benefit overall; from a utilitarian point of view, it generally doesn't matter who benefits, just that someone benefits. Faced with two potential recipients of a given benefit, one well off, the other worse off, as long as the size of the benefit is the same, utilitarianism is indifferent to whom the benefit accrues. The same logic applies when the recipients in question differ in age (e.g., one is a child, the other a senior). As long as the size of the benefit is the same, utilitarianism is indifferent to age. A utilitarian ageist approach to the surgical backlog might prioritize the young, or it might not. Age is not directly relevant, only the maximization of benefit. This implication will strike many advocates of paediatric exceptionalism as counterintuitive because they believe young people deserve priority *because* they are young.

A closely related challenge flows from the contingent nature of utilitarian justification. Utilitarian arguments in support of paediatric exceptionalism are empirical in nature. Though prioritizing the young may maximize benefit in many cases or contexts, in others this approach may support decisions to prioritize other age cohorts. This contingency flows from the indirect role played by age in the moral calculus of utilitarianism – from a utilitarian point of view, only the overall size of the benefit matters. Returning to the surgical backlog, if it maximizes overall benefit to allocate health resources to the elderly, from a utilitarian point of view this policy is morally justified even if it means that children and youth are thereby disadvantaged. This contingent connection between age and priority will strike some advocates of paediatric exceptionalism as counterintuitive because, for them, the connection between priority and age is necessary or analytic (i.e., true by definition). Again, young people deserve priority *because* they are young.

For supporters of paediatric exceptionalism, matters are made worse by another well-known challenge levied against utilitarianism: the aggregation problem. Since there are typically many more older adults than young children, even if the individual benefits of surgery for older patients are smaller, in aggregate the overall benefits of meeting the minor needs of older people may outweigh the benefits of meeting major needs of the young because the former outnumber the latter (12). In this way, a utilitarian approach to allocation may actually undermine a paediatric exceptionalist approach to the surgical backlog as there are in fact many more adults waiting for surgery than children.

Fair Innings

For all of these reasons (and more), many advocates of paediatric exceptionalism prefer to appeal to the fair innings argument. John Harris is often cited as an early source of this account. In Harris' words, the fair innings argument captures the common intuition that "while it is always a misfortune to die when one wants to go on living, it is not a tragedy to die in old age; but it is on the other hand both a tragedy and a misfortune to be cut off prematurely." (12, p.93) Accordingly, the fair innings argument holds that "people who [have] achieved old age or who [are] closely approaching it [should] not have their lives further prolonged when this could only be achieved at the cost of the lives of those who [are] not nearing old age." (12, p.93-4)

The basic supposition at the core of this account is that all persons are deserving of a normal lifespan (12). From this perspective, a just society is one that recognizes an obligation to help young people become old but is under no obligation to help the old become indefinitely older (13). This approach is sometimes called the "complete lives" account because it argues that younger persons should be enabled to live a complete life, where 'complete' is typically defined in terms of a 'normal lifespan.'

Let us return, once again, to the current surgical backlog and consider how the fair innings argument would play out. Two considerations immediately come to mind. First, the fair innings argument will only provide meaningful guidance in terms of allocation when focused on individuals or groups who are located on either side of the complete life threshold. As we saw above, the fair innings argument is agnostic with respect to allocations between individuals or groups beneath the threshold, other things being equal. Second, since the surgical backlog is not comprised of life-saving interventions (which were prioritized during the pandemic), one might wonder if the fair innings argument actually applies. After all, the fair innings argument appears to be concerned with the length of people's lives not necessarily their quality.

Assuming the fair innings argument can be meaningfully applied to the allocation of non-life-saving interventions, it seems clear that the fair innings argument will support a paediatric exceptionalist approach to the surgical backlog *when allocations are made across the complete-life threshold*. If a seventeen-year-old and a seventy-year-old both require elective surgery long delayed by shut-downs during the pandemic, but resources are constrained such that only one of them can be treated, the fair innings argument appears to support the conclusion that, other things being equal, the seventeen-year-old should be prioritised.

Note, furthermore, that the fair innings argument avoids many of the challenges faced by utilitarian ageism. Specifically, the fair innings argument appeals to considerations of fairness rather than benefit-maximization, thereby avoiding utilitarian ageism's counterintuitive insensitivity to distributional or equity-based concerns. The role of age is direct – age itself is an independent moral criterion for prioritizing the young. Thus, counterintuitive results that flow from the contingent, empirical nature of justification in utilitarian ageism are avoided. Though fair innings theorists do not use the term, paediatric exceptionalism is *entailed* by this view.

Assessing fair innings

One type of objection to the fair innings argument challenges its reliance on the notion of a "complete life." Recall that the supposition at the core of the fair innings argument is the notion that all persons are deserving of a normal lifespan. As already discussed, this argument provides support for the widely shared intuition that, other things being equal, a seventeen-year-old should be prioritized over a seventy-year-old – assuming we agree that seventy is a reasonable threshold. Clearly, however, this assumption is open to challenge. The average lifespan in Canada is now 79.5 and 83.0 years for men and women respectively (14); and should this average lifespan be taken as the marker of a complete life? It is easy to see that any threshold identified will be open to challenge, in part because this is an arbitrary threshold and also one subject to change over time. Another challenge to any view that relies on such a threshold is that whatever it may be, we will struggle with justifying differential treatment for those who fall just above or below; such minor differences in age are obviously meaningless and differential treatment across them unjustifiably arbitrary.

The complete lives account generates other counterintuitive results. If differences in age that cross the threshold are morally salient, what about differences that do not cross the threshold? Put another way, why is a complete life the only source of value? Other things being equal, isn't more time better than less? Shouldn't any difference in age be morally salient? Not according to the complete-lives version of the fair innings argument. If the threshold is seventy years of age, other things being equal, a fifty-year-old is just as deserving of resources as a five-year-old. One consequence of this feature of the fair innings argument is that it cannot provide guidance for the large number of allocation decisions involving patients who fall below the threshold of a "complete life." This will necessarily limit the utility of this argument with respect to the surgical backlog.

Worse (from the perspective of someone advocating paediatric exceptionalism), the complete lives version of the fair innings argument can result in allocation decisions that prioritize older patients over younger patients. Imagine a ten-year-old and a sixty-year-old, both in line for an intervention that will extend their lives for ten years. At first glance, the fair innings argument does not distinguish between these patients – until it is noticed that the sixty-year-old patient may in fact achieve a complete life with the intervention, whereas the ten-year-old has no hope. Here, it seems, the fair innings argument is turned on its head, working to justify allocation to the older patient at the expense of the younger (10). This result should be troubling for anyone who is committed to defending paediatric exceptionalism.

At this point, we turn to another approach to allocation. Unlike utilitarian ageism, this approach is non-consequentialist but like the fair innings argument, it is focused primarily on distributional fairness. Yet unlike the fair innings argument, it is not committed to age-based allocation.

The Prudential Lifespan Account

In *Just Health Care*, and more recently in *Just Health,* Norman Daniels explores the topic of justice as it applies to health and health care (15,16). Daniels's work is based largely on the work of John Rawls (17), thus he begins with the supposition that justice as fairness requires the protection of opportunity (as per Rawls). Daniels then argues that health is of special moral importance because normal functioning (i.e., health) is necessary for, and protective of, opportunity. Health care, in turn, protects normal functioning. Therefore, justice gives special importance to health care and a theory of just health care must give an account of the just allocation of health care resources (14).

Daniels' approach to allocation between age groups is called the prudential lifespan account. The central intuition behind this account is that "prudent allocation among stages of our lives is our guide to what is just between the young and the old." (15, p.172) Instead of viewing age groups in competition with one another (i.e., young vs. old), Daniels asks us to view each age group as representing a stage of our lives. Next, Daniels deploys Rawls' "veil of ignorance". We are asked to pretend that we do not know how old we are, and to then allocate a lifetime fair share of health care resources across the stages of our life. According to Daniels, this process results in an allocation policy that is fair to different age groups, even when different age groups are treated differently.

The prudential lifespan approach may or may not support a paediatric exceptionalist approach to the surgical backlog; it depends on the allocation policy that results from deliberation under the veil of ignorance. That said, Daniels is careful to point out that the prudential lifespan does not advocate for age-based allocation as a general policy. He does allow, however, that it may well support it under limited conditions "when there is no more prudent alternative." (15, p.180)

Assessing the prudential lifespan account

For present purposes, the central problem with Daniels' account is that it doesn't actually tell us how to allocate health care over the course of a lifespan. By extension, it doesn't provide us with concrete guidance with respect to the surgical backlog. Should younger patients be prioritized? Is paediatric exceptionalism justified? Who knows? The process described – prudential deliberation under the veil of ignorance concerning the allocation of a lifetime of fair share of resources – is suggestive. It shifts our perspective in helpful ways and encourages impartiality. What it does not do, however, is provide us with clear answers. As Daniels avers, "The Prudential Lifespan Account does not tell us how to ration services over the lifespan… Reasonable people will draw different conclusions from the moral theories they invoke and the different weight they give to specific moral intuitions." (15, p.180-1) This is why Daniels supplements his account with a fair deliberative process. Even then, however, it is likely that different deliberative processes will result in different distributions.

Prioritarian Ageism

Utilitarian ageism is insensitive to distributional inequity and only contingently sensitive to the moral relevance of age. The fair innings argument is problematic as well, as it relies on a complete lives threshold which is both hard to justify and generates counterintuitive results. Finally, the prudential lifespan approach provides very little determinative guidance. What we need is an argument that retains the strengths of utilitarian ageism and fair innings while avoiding their weaknesses. Greg Bognar defends a view he calls “prioritarian ageism,” which appears to satisfy these desiderata (12).

Prioritarian ageism (prioritarianism) is a consequentialist approach to paediatric exceptionalism but, unlike utilitarian ageism, it does not attribute the same value to all additional life years. According to the prioritarian view, life years are assigned more value the younger the person, less value the older the person (imagine a convex curve that starts out almost vertical then becomes increasingly flat as it moves up and to the right, where age is on the x axis and value is on the y axis). Thus, while prioritarianism is a consequentialist view, the right policy is not the one that maximizes life years *simpliciter* but the policy that maximizes *the age weighted sum* of life years.

Assessing prioritarianism

Prioritarianism addresses many of the objections to utilitarian ageism noted above. First, because the value of additional life years is age weighted, the support provided by prioritarianism for paediatric exceptionalism is not purely contingent as it is in utilitarian ageism. A commitment to paediatric exceptionalism is built into prioritarianism via the age based weighting scheme involved. That said, the resulting distribution is still contingent on which approach actually maximizes the age weighted sum of life years; the resulting distribution is sensitive to age but not determined by it. Thus, a prioritarian approach to the surgical backlog might result in allocations that prioritize the elderly, but this result is much less likely than it is in utilitarian ageism because the value of additional life years for the elderly is much smaller than it is for the young.

For the same reason, prioritarianism is resistant (though not immune) to the aggregation problem. The aggregation problem, recall, occurs when minor benefits to many older people outweigh major benefits to a young person. From a prioritarian point of view, this outcome is still possible but much less likely than it is from a utilitarian point of view, again, because of the diminishing value of additional life years for older people. This feature of prioritarianism is crucial in the context of the surgical backlog. As noted above, there are many more adults on the waiting list than children. The aggregation problem does threaten to undermine paediatric exceptionalism if we are concerned only with maximizing benefit overall. By focusing on the maximization of age-weighted benefits, a prioritarian approach reduces the risk that major benefits to the young will be missed, while retaining sensitivity to contexts where – due to the overall size of the aggregate benefit – it will nonetheless be maximizing to prioritize older patients.

Prioritarianism also avoids objections to utilitarian ageism based on the latter’s insensitivity to the distribution of benefits. Though prioritarianism is a consequentialist view, because it is concerned with maximizing age weighted value, it will tend to distribute benefits to the young (though not always).

Finally, prioritarianism retains the strengths of the fair innings argument while avoiding its weaknesses. Like the fair innings argument, prioritarianism is sensitive to age in the distribution of health resources. Unlike the fair innings argument, however, prioritarianism is not reliant on an age-based threshold or the notion of a complete life; it is sensitive to age differences across the lifespan. Given the difficulties involved in justifying such a threshold, this is a strength of the view. Furthermore, this feature of prioritarianism also allows it to sidestep other counterintuitive results noted above. Major differences in age beneath the threshold remain morally salient, as they should, while minor differences in age will not carry much moral weight.

DISCUSSION

As we presented above, utilitarian ageism, fair innings, the prudential lifespan approach, and prioritarian ageism provide variable support for paediatric exceptionalism. We also examined significant objections to utilitarian ageism, fair innings and the prudential lifespan account. Prioritarianism, by contrast, appears to maintain the strengths of these views while avoiding their weaknesses.

At this point, we want to consider another kind of objection to which all views that provide support for paediatric exceptionalism are potentially liable. The objection is this: insofar as these views support prioritizing the young over the old with respect to the allocation of health resources, they are discriminatory or ageist in the negative sense of that term. In a Canadian context, this criticism can be made more concrete by noting that governments in Canada are constrained by the (section 15 of the) Charter of Rights and Freedoms which prohibits discrimination on the basis of age, among other protected characteristics (18). Similar constraints on public policy prevail in other jurisdictions. The objection, in sum, is that any allocation scheme that prioritizes the young over the old will be subject to a rights-based challenge of this sort. The concern for present purposes is that, insofar as the accounts of just allocation canvassed above support paediatric exceptionalism, they too are discriminatory.

To begin to respond to this objection, consider that the Charter allows for actions or policies that would otherwise violate a constitutionally protected right or freedom if it can be shown that such a policy is fair and not arbitrary (19)[1]; similar provisions exist in other jurisdictions. The challenge for paediatric exceptionalist policies is that it is unclear whether they are or can be "fair and not arbitrary" in this sense. In the rest of this section, we examine how each of the four views we have reviewed above hold up in relation this criterion.

First, consider the prudential lifespan account. Insofar as this approach results in differential treatment of different age groups, and this does seem likely, resulting policies may be subject to rights-based objections. Daniels responds to this sort of objection by arguing that distributing resources based on age is different than choosing to disseminate resources based on race or sex because everyone ages (16). "[If] we treat the young one way as a matter of policy and the old another way, and if we do so over their whole lives, then we treat all persons the same way. There is no inequality between persons since each person is treated both ways in the course of a complete life." (15, p.171)

At first blush, Daniels response is quite compelling. Shifting the focus from competition between age cohorts to allocation across the lifespan does seem like a step forward. Furthermore, by explicitly focusing on a process whereby principles of just health resource allocation are identified for a society as whole, his approach lends itself to macro level policy making and (perhaps optimistically given the realities of political decision making) the kind of consistency over time that his response above requires.

On the other hand, much turns on the details of deliberation under the veil of ignorance. Who is at the table? And what arguments do they offer? It seems very likely that, when faced with the task of allocating a lifetime fair share of health care resources across the stages of a life, deliberators will invoke consequentialist considerations like those in utilitarian ageism and prioritarianism, or considerations related to fairness like those captured by fair innings and, perhaps, other arguments. It is far from clear, in other words, that the prudential lifespan account provides any independent argument(s) for paediatric exceptionalism. Absent a substantive account of 'prudence,' it seems likely that arguments about 'prudent' allocation will repeat extant arguments about allocation. Insofar as deliberation behind the veil of ignorance relies on extant arguments, deliberators will take on the strengths and weaknesses of those arguments and, along with them, the liability to charges of discrimination. The veil of ignorance does nothing to allay this concern unless it also provides deliberators with a new language of justice.

Next, we turn to the fair innings argument. In this argument, recall, age itself provides an independent moral justification for prioritizing the young. As we saw above, this feature of the fair innings argument is one of its strengths. The direct connection between age and distribution ensures that policies based on the fair innings argument are addressed to the sort of distributional inequities with which advocates of paediatric exceptionalism are characteristically concerned. The direct connections also eliminate the contingency associated with utilitarian ageism.

But this direct connection with age is also a liability as it is far from clear that paediatric exceptionalist policies justified on fair innings grounds can be fair and not arbitrary in the relevant sense. Such policies appear to justify ageist measures (prioritizing the young) by invoking ageist reasons (the priority of the young). But discriminatory reasons are paradigmatic of arbitrary reasons. At first blush, it seems that we cannot just appeal to age to justify age-based prioritization (i.e., paediatric exceptionalism) without violating this criterion. Non-arbitrary reasons in support of age-based prioritization will necessarily involve appeal to factors other than – or additional to – age. Since, by definition, fair innings arguments only apply when everything but age is equal, this strategy is not available. Thus, while it is possible that policies based on the fair innings argument could be justified, the argumentative road is steep and narrow.

By contrast with the fair innings argument, age plays an indirect role in allocation in both utilitarian and prioritarian ageism. As we saw above, age plays a purely contingent role in utilitarian ageism. If and when paediatric exceptionalism is maximizing, utilitarian ageism will provide support for it; when it doesn't, it won't. The role of age in prioritarianism is more central, as prioritarian ageism is focused on the age-weighted sum of life years (where additional life years are a proxy for additional well-being). Nonetheless, while age is a factor in decision making in prioritarianism, it does not play a direct role in the moral justification of allocation. Instead, as in any consequentialist view, moral justification is provided by maximizing value (in this case well-being). This feature (the indirect role of age) of both utilitarian and prioritarian ageism goes some way towards mitigating rights-based objections. Furthermore, the prospects of an allocation policy based on these views successfully negotiating rights-based objections look correspondingly stronger.

These considerations, along with our previous observations concerning the comparative strength and weaknesses of the views canvassed above, lead us to conclude that a prioritarian defense of a paediatric exceptionalist approach to the surgical backlog

[1] Canada's Charter of Rights and Freedoms allows for actions or policies that would otherwise violate a constitutionally protected right or freedom if it can be shown that such a policy satisfies the criteria specified in the so-called 'Oakes Test':

1. The objective to be served by the measures limiting a Charter right must be sufficiently important to warrant overriding a constitutionally protected right or freedom.
2. The party invoking s. 1 must show the means to be reasonable and demonstrably justified. This involves a form of proportionality test involving three important components.
    a. To begin, the measures must be fair and not arbitrary, carefully designed to achieve the objective in question and rationally connected to that objective.
    b. In addition, the means should impair the right in question as little as possible.
    c. Lastly, there must be a proportionality between the effects of the limiting measure and the objective -- the more severe the deleterious effects of a measure, the more important the objective must be (18).

is most likely to succeed. Once again, prioritarian ageism retains the strengths of utilitarian ageism and fair innings, while avoiding their weaknesses. Furthermore, because prioritarianism invokes considerations that are correlated with but not directly based on age, it is ostensibly non-arbitrary, non-discriminatory, and less susceptible to human-rights based objections.

CONCLUSION

In the context of the surgical backlog, the ethical defensibility of resource allocation decisions is especially salient. The COVID-19 pandemic has forced societies to grapple with the allocation of scarce health care resources and brought renewed focus to questions of distributive justice. Decision makers responsible for allocating resources in a publicly funded healthcare setting must be prepared to justify their decisions and be transparent about the values driving their choices. Paediatric exceptionalism may be ethically defended by appeal to utilitarian ageism, fair innings, the prudential lifespan account, and prioritarian ageism. On the other hand, utilitarian ageism, fair innings and the prudential lifespan account are also subject to powerful objections that extend to paediatric exceptionalism justified on these grounds. For these reasons, we have advocated for the adoption of prioritarian ageism as a justification for a paediatric exceptionalist approach to resource allocation. We believe that prioritarian ageism retains the strengths of the other views while avoiding their weaknesses. Furthermore, because prioritarianism invokes considerations that are correlated with but not directly based on age, we believe it is less susceptible to human-rights based objections in general, and (in a Canadian context) Charter challenges in particular.

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