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EDITORIAL

Clarifying the Discussion on Prioritization and Discrimination in Healthcare

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Discrimination is an important real-life issue that affects many individuals and groups. It is also a fruitful field of study that intersects several disciplines and methods. This Special Section brings together papers on discrimination and prioritization in healthcare from leading scholars in bioethics and closely related fields.

Lasse Nielsen opens the section with a paper that offers and defends a patient-sensitive account of health-related quality of life. According to Nielsen, such an approach can effectively make cost-effectiveness less discriminatory against disabled people. This perspective is needed because of, what he refers to as: the disability discrimination problem. The problem involves, other things being equal, that resources spent on disabled people are spent less cost-effectively than when spent on nondisabled people. In practice, this means that the standard cost-effectiveness models discriminate against disabled people and therefore, the models need to be amended.

In her commentary on Nielsen, Julia Mosquera contends that contrary to what Nielsen proposes, his model might still, in certain circumstances, lead to the unfair prioritization of some nondisabled patients over disabled ones.

Anders Herlitz continues the discrimination discussion and argues that the cost-effectiveness analysis used in the healthcare sector creates a discrimination risk. He shows how the standards used in these analyses fail to fully determine an optimal option, and that leaves the decision-makers with a large set of permissible options. This, he maintains, can increase the role of decision-makers' biases, whims, and prejudices, which in their turn, can increase the risk of discrimination.

In his paper, Ben Davies addresses the thorny question of whether age is relevant to healthcare priority-setting. Davies holds that, from the start, there is a certain ambiguity involved in the issue. We often say things like: "Patients classified as young should have a high priority," but also that "Patients classified as old should have a low priority." Davies' point is that, in general, equity cannot justify giving "old" patients low priority since there is a wide variety in the total lifetime experience of such patients—influenced by gender, race, class, disability, and so forth. He concludes, however, that there might be a limited role for age-based prioritization in the context of very early life, because, arguably, those who die at a very young age are always among the worst off.

In their contribution, Iñigo de Miguel Beriain, Ekain Payan Ellacuria, and Begoña Sanz tackle the issue of human germline editing. The authors show that there are embedded gender issues involved that have not been given their proper attention. This has allowed germline editing the potential to become a tool of oppression against women, while, properly understood, it could also be used for female empowerment.

Maximiliane Hädicke, Manuel Föcker, Georg Romer, and Claudia Wiesemann study the ethical issues related to treating transgender minors. According to the authors, the most crucial question is whether the patients are treated as minors or as transgender individuals. The authors conclude that an intersectional approach is needed to address the matter.

The section closes with a puzzle presented by Kasper Lippert-Rasmussen that goes as follows: The general assumption is that the distribution of healthcare is morally justified only if (1) it is cost-effective

and (2) it does not discriminate against older adults and disabled people. However, if (3) cost-effectiveness involves maximizing the number of quality-adjusted life years, it seems the pursuit of cost-effectiveness will inevitably discriminate against older adults and disabled patients. In the article, Lippert-Rasmussen shows that this trilemma is harder to reject than people think. As a solution, he offers reasons to doubt the necessity of the first claim. If he is correct, the distribution of healthcare can be morally justified even if it is not cost-effective.

Discrimination perpetuates differences in power, authority, and deference. Treating some people as inferior rather than equal is especially worrying when happening in the context of healthcare because of the distribution of important resources and the institutional role involved in the process. But with scarce resources prioritization is necessary. The Special Section papers hopefully clarify the discussion on discrimination and prioritization in healthcare and offer plausible answers to some important practical questions.

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