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Theoretical Underpinnings of the Political Priorities of Municipal Healthcare Services in Norway

How a Rawlsian Heuristic Can Aid Political Decision-Making in Municipal Healthcare Services

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Abstract

This paper aims to discuss the current criteria for municipal priorities in municipal healthcare services in Norway in light of major theories from political philosophy on social justice, such as John Rawls's theory of justice and utilitarianism. Our first goal is to show that perspectives from political philosophy could prove useful for increasing our understanding of the current priority-setting criteria in municipal healthcare services.

Decision-makers in municipalities often have to exercise discretion in their decisions. We argue that the current criteria of *health benefit*, *resource use* and *severity* can introduce some indeterminacy in certain situations where municipalities have to make priorities. This is important, as municipalities are experiencing an increase in demand coupled with a decrease in capacity due to an ageing population, leading to a stronger need for prioritization between services.

Our last goal is to provide a heuristic based on Rawls's Original Position that may help to narrow indeterminacy in choice situations. We have included a case of municipal decision-making that focuses on municipal priority-setting in home care services, including assisted living facilities, nursing homes and preventative measures.

Keywords
Rawls, utilitarianism, priority-setting criteria, municipal priorities, municipal health and care services

Introduction

This paper aims to discuss the Norwegian government's priority-setting criteria in municipal healthcare services and how they reflect perspectives from political philosophy. We argue the current criteria for priority-setting may lead to indeterminacy in certain municipal decision-making situations. Lastly, we propose a Rawlsian heuristic to narrow this indeterminacy.

A discrepancy exists between the population's health needs and expectations, what is medically feasible and what is realistically deliverable by the government. This necessitates political prioritization (e.g., Norheim, 2016; Ottersen et al., 2016; Solberg et al., 2022; Stenmarck et al., 2023). The need for municipal healthcare services is expected to increase in Norway; the proportion of people aged 67+ in relation to the number of people aged 18–66 is expected to increase from 25% in 2022 to 37% in 2040, and the largest increase will be among those aged 80 and over (NOU 2023: 4). In 2019, there was an estimated shortfall of 5500 nurses nationwide, projected to increase to 28,000 in 2035 (Hjemås et al., 2019). Shortages also exist among other health personnel groups (Helsedirektoratet, 2022). Municipal access to financial resources is a primary factor for coverage of elderly care, and the projected population changes imply a smaller taxpayer base bearing the cost (Martens, 2018). Consequently, municipalities are facing increasing demands coupled with a fall in deliverance capability, making prioritizing in municipal healthcare harder. This may be exacerbated in rural municipalities with higher proportions of elderly relative to the working population (Bovim & Nerdrum, 2023; NOU 2020: 15; NOU 2023: 4).

Priority-setting in healthcare has been a longstanding topic. The government has issued five white papers on health priority-setting since 1987, but only one (2018) on *municipal* priority-setting (Solberg et al., 2022). The balancing of principles has been debated – for example between the utilitarian principle of *the greater benefit* and the prioritarian principle of *benefitting the worst-off* (Ottersen et al., 2014) – and the egalitarian issue of 'levelling down' (Norheim, 2009). Haldar et al. (2020) investigates three white papers from 1987 to 2014 and finds a replacement of sociological and ethical-philosophical perspectives with economic utility and individual rights perspectives. Similarly, Hofmann (2013) argues that the aim of the report from 1987 was 'based on ideals of equal access and solidarity with the vulnerable', changing when *utility* and *individual rights* were introduced in a health priority-setting in the 1990s and 2000s.

Horn, Jølstad et al. (2021) find fewer studies on the cost and effect of measures in municipal healthcare than in specialist healthcare, making municipal priority-setting more difficult. They also argue that a clearer specification of severity in preventative measures is needed, as preventative measures are often given lower priority. Førland et al. (2021) have found that utilitarian and prioritarian principles often come into conflict in practice. They also found municipal health priority-setting sometimes to be in conflict with municipal finances, rules and laws, internal organization, control systems and professional knowledge. Further, preventative measures are often found to be down-prioritized due to more pressing issues.

Norwegian municipalities are self-governing, separate legal entities within limits set by law, and with a freedom of choice to engage in any task not legally assigned to other authorities (Danielsen et al., 2019; Hansen, 2005). There is tension between national standards and ambitions versus municipal autonomy (Danielsen et al., 2019; Martens, 2017): 80% of the tasks for which municipalities are responsible are decided by the national parliament (Jenssen & Robertsen, 2015). Danielsen et al. (2019) argue that while municipal autonomy is heralded by political parties and government, the actual implementation of policies is becoming

more centralistic. Martens (2017) argues that there has been an increase in central legislation in eldercare policies between 1993 and 2014.

The Norwegian priority-setting of healthcare services is guided by principles built upon ideas of *moral egalitarianism*, meaning all humans are equal in fundamental worth or moral status, and that governments should show equal concern for the life of each citizen (Arneson, 2013; Dworkin, 1987, pp. 7–8). This differs from other egalitarian ideas, such as equality of health outcomes (Norheim, 2009). Other ideas such as universalism, equity/equality and distributive justice are taken to be implications of this moral egalitarianism. This is well founded: contemporary debate in social justice starts from the assumption that all citizens have an equal abstract moral right to welfare services (Kymlicka, 2002, pp. 1–5). The legal framework and the main empirical material for this paper are the three current *priority-setting criteria* underlying priority-setting in municipal healthcare: *a health benefit criterion*, *a resource use-based criterion* and *a severity-based criterion*; these are similar to those in specialist healthcare (Meld. St. 38 (2020-2021)). The criteria are meant to work on several levels, but we are mostly concerned with the political/administrative level, and explicitly not the clinical level.

Political priority-setting in municipal healthcare services differs from specialist healthcare on several accounts. Firstly, people live their whole lives in municipalities, and with varying needs. Political decisions regarding municipal healthcare services are therefore complex, with a lifelong time scale (Horn, Jølstad, et al., 2021; NOU 2018: 16, pp. 76–86). Secondly, many decisions concerning municipal healthcare services are made by local politicians, travelling short distances with swift impact on their electorate. Also, municipal resource spending in healthcare is balanced against educational needs and infrastructure (NOU 2018: 16). Thirdly, it is not given that priority-setting criteria should be the same in clinical and political settings (Rawls, 1999, p. 7, 2001, pp. 14–18).

We seek to fulfil our aims in this paper by answering two research questions:

- *How do the current priority-setting criteria in municipal healthcare services reflect perspectives from political philosophy, such as John Rawls's theory of justice and/or utilitarianism?*
- *What are some of the merits and drawbacks of the current priority-setting criteria in municipal healthcare services when used on a political level, and how can drawbacks such as indeterminacy be addressed in local political decision-making?*

Note that a fictional case is provided as an illustration in addressing research question two. Indeterminacy, as elaborated in the discussion, is tied to complexity, difficulty of measurements and calculations, underspecification of definitions of utility, and underdetermination of local factors.

Theoretical Framework

According to Tännsjö (2019), the three most promising theories for distributive justice in health are utilitarianism, maxi-min/lexi-min theory based on Rawls, and egalitarianism. We focus here on utilitarianism and Rawls's theory of justice[1].

1. Egalitarianism is not discussed further here as we have found its further relevance to the research questions and empirical material to be limited. We refer to the introduction and its discussion of moral egalitarianism as foundational.

Rawls's Principles of Justice

It is fair to say that modern political philosophy starts with John Rawls's *A Theory of Justice* from 1971 (Rawls, 1971, 1999). Rawls's main concern in *A Theory of Justice* was to provide an alternative to utilitarianism. These are the principles of justice as Rawls formulates them in *Political Liberalism* (Rawls, 1993, p. 291).

1. The liberty principle: 'Each person has an equal right to a fully adequate scheme of equal basic liberties which is compatible with a similar scheme of liberties for all.'
2. Second principle: 'Social and economic inequalities are to satisfy two conditions. First, they must be attached to offices and positions open to all under conditions of fair equality of opportunity; and second, they must be to the greatest benefit of the least advantaged members of society.'

The liberty principle mandates an equal distribution of basic liberties, such as freedom of speech, private property rights, the right to a fair trial etc. The first part of the second principle is known as the principle of fair equality of opportunity, and the latter part of the second principle is known as the difference principle, which is a maximizing principle: we are to maximize the expectations of the least advantaged social group (maxi-min) (Rawls, 1999, p. 69). The liberty principle has lexical priority over the second principle, and the first part of the second principle has priority over the last part. This requires that we must first satisfy the liberty principle before turning our attention to the second principle, and likewise with the first part of the second principle (Rawls, 1993, pp. 294–297).

According to Rhodes (2008), Rawls's liberty principle is given broad endorsement in medical ethics and literature and is commensurable with a moral egalitarian position of people having equal moral status (Dworkin, 1987, pp. 7–8, 14–15). Attention is also given to the difference principle, which is sometimes referred to as the origin and a variation[2] of *prioritarianism* (Rhodes, 2008). Daniels (1979a, 2001, 2007) argues that healthcare should be treated as a basic need, and that at least some healthcare services should be considered a Rawlsian *social* primary good; a good that is socially distributed, and one that citizens must have in order to be fully participating, free and equal citizens in a fair society.

Rawls' Method of Justification: Reflective Equilibrium and the Original Position

Methodologically speaking, philosophical work is generally characterized by appeals to moral intuitions, reasoning from analogy, and attempts to make intuitive and theoretical considerations fit together. Rawls is no exception: his method of justification is called 'wide reflective equilibrium'[3]:

2. The first mention of the term prioritarianism is in Temkin (2000), who argues that this term is synonymous with his own idea of extended humanitarianism and Parfit's conception of the priority view (Parfit, 1997). Parfit argues in an appendix that Rawls's difference principle may indeed be categorized not only as compatible but also as a (rather extreme) version of his priority view, where the worse-off have a veto and absolute priority. As such, Rawlsian arguments are often included in health priority discussions, although under the umbrella of prioritarianism or the priority view (for example, in Norheim, 2009; Ottersen et al., 2014).
3. We would like to make a note about empirical methods in the methods chapter being different from philosophical methods such as Rawls's method of reflective equilibrium and the Original Position elaborated upon here. While the latter is also referred to as a type of method, it is not utilized by us authors as we do not put ourselves behind a veil of ignorance, and so forth. It is also distinct from any empirical method utilized by the authors and deliberately placed apart.

> A conception of justice cannot be deduced from self-evident premises or conditions on principles; instead, its justification is a matter of the mutual support of many considerations, of everything fitting together into one coherent view (Rawls, 1999, p. 19).

The *Original Position* is a thought experiment that Rawls uses to achieve such an equilibrium. In essence, we are to imagine that we discuss and select principles of justice under a *veil of ignorance*:

> The aim is to rule out those principles that it would be rational to propose (…) only if one knew certain things that are irrelevant from the standpoint of justice (Rawls, 1999, p. 17).

An obvious example noted by Rawls is knowledge of the fact that one is wealthy. This knowledge would make it rational to favour principles that do not allow taxation for the sake of providing social welfare services to the worst-off (Rawls, 1999, p. 17). Similarly, if one knows that there is little history of dementia in the family etc., then it would be rational to prioritize differently than if the opposite were true. The *veil of ignorance* excludes such information.

All we know are general facts about society and human nature. We do not know particular facts about our own society, or even particular facts about ourselves – for example, whether we are able-bodied or disabled, or our religion, gender, wealth, sexual orientation etc. Furthermore, we imagine that all we care about is advancing our own interests as effectively as possible. We are not moved by compassion, envy, love, hatred etc. for others (Rawls, 1999, pp. 118–130).

In essence, the Original Position models certain 'background theories' about justice (Daniels, 1979b). It reflects what Rawls takes to be plausible conceptions of personhood, a fair contract, impartiality etc.; impartiality in particular will be important for this paper. However, the outcome of the position should also cohere with our considered moral convictions (e.g., 'slavery is wrong'). If the principles violate our firm and shared moral convictions, we must either revise these judgements, how the position models our background theories about justice, or these theories themselves. In short: in justifying the principles, we work 'back and forth, sometimes altering the [description of the Original Position], at others withdrawing our judgements and conforming them to principle …' (Rawls, 1999, p. 18).

It should be clear, then, that the Original Position is nothing but a tool for reflection. The quintessential idea of the Original Position as part of the philosophical method of wide reflective equilibrium is to facilitate the move from abstract and general theoretical reflections to more concrete and action-guiding principles, such as Rawls's own principles of justice (Rawls, 1985, p. 238).

Utilitarianism

Put briefly, utilitarianism is the ethical theory that contends that one ought to maximize the net sum of utility, also called well-being (Crisp, 2021; Wolff, 2016). We can first distinguish between forms of utilitarianism in accordance with their *account of well-being*; one account being *hedonism*, where well-being consists of pleasure and the absence of pain (e.g., back pain). Pain as such diminishes a person's well-being independently of their attitude towards it and independently of whether it prevents them from performing normal day-to-day tasks or having a dignified and normal independent life. The second form takes well-being to consist of *the satisfaction of preferences*: what is good for me is to get what I prefer. The third main theory of well-being is *objective list theory*, according to which things are good or bad for a person independently of their preferences/attitudes and whether they cause feelings

of pleasure/pain (Crisp, 2021). This element is clearest in the talks of 'coping' (Norwegian: *mestring* or *livsmestring*) in policy documents[4].

Mainstream utilitarianism tells us to maximize the net sum of well-being. In a political context, there are also versions of utilitarianism (in a looser sense) that tell us to promote or protect well-being in other ways. One version is to *maximize average life quality* (see Rawls, 1999, pp. 139–152). A second is to *maximize the number of good years of living* (measured in Quality-Adjusted Living Years, QALYs), which is the form of utilitarianism most present in our empirical material. For a definition of the QALY, see Ottersen et al. (2016) or the following empirical section. In this conception, utility is a threshold concept where differences above the threshold of a good year do not matter. Living a good year means not being sick and being relatively independent (coping is relevant, but not included in the QALY measure). A third version is to *minimize suffering* or 'negative utilitarianism' (Walker, 1974) – for example, maximizing average life quality for the worst-off. This is a version of utilitarianism that comes closer to a maxi-min-like rationale.

Method of Empirical Analysis

The underlying principles of priority-setting in healthcare are intangible ideas, and *policy documents* were chosen as the most time-efficient method to identify empirical expressions of these principles.

This is defendable as we investigate *what* the content of the principles are, not *why* or *how* they have been produced. Policy documents have been viewed as 'technologies of politics', as they can make something possible (Asdal & Reinertsen, 2020). Empirically, this study is based on analysis of policy documents written by the central government that were identified as nodal in defining principles for prioritizing in the Norwegian healthcare system. Key concepts were identified and considered based on the theoretical framework, and searches were conducted in public online government document archives to find relevant documents (Regjeringen.no, 2023).

Based on the criteria of authority, centrality and nodality, we identified and selected three nodal policy documents for the purpose of our analysis – one white paper and two grey papers. Priority-setting in municipal healthcare is most clearly expressed in the white paper *Report to the Storting [parliament] number 38 2020-21, Utility, resource and severity prioritizations in health and care services* (Meld. St. 38 (2020-2021)), which itself is based on two official reports/grey papers: the Blankholm report (NOU 2018: 16) and the Norheim report from 2014 (NOU 2014: 12). We reviewed these documents and circled sections where principles underlying priority-setting in the healthcare system were either mentioned explicitly or could be inferred indirectly, or when key concepts tied to criteria of priority-setting were discussed. We then read the identified passages through the lens of *idea analysis*, implying 'qualitative analysis of the presence of ideas in texts, where interpretation constitutes a large part of the analysis (…) [in order] to grasp its underlying assumptions and convictions' (Bratberg, 2014, p. 57, our translation).

4. Coping is a main goal, and there are no (explicit) qualifications that the subjects must be interested in coping or that it involves happy feelings.

Empirical Material: The Current Priority-Setting Criteria

The Norwegian government currently operates with three priority-setting criteria in municipal healthcare: (1) *a health benefit criterion*, (2) *a resource use-based criterion*, and (3) *a severity-based criterion* (Meld. St. 38 (2020-2021)). These criteria prescribe a given measure to be increasingly prioritized with increased health benefit, decreased resource use and/or increased severity, and are intended to work on different strata in healthcare, including clinical, group, administrative, and political levels. Below is a representation of the procedure and operationalization of its key concepts:

> Priority-setting of an intervention or measure is calculated through…→ cost/effect → check for opportunity cost → weighted by severity (Meld. St. 38 (2020-2021), pp. 60–61).

All relevant monetary *costs* or other forms of resource spending in healthcare services, including time, should be considered as far as possible. Consequences on the patient's future productivity, future use of public services and/or receipt of benefits/pensions should not be given weight. *Effect* is operationalized as expected gain measured as 'Quality-Adjusted Living Year' (QALY), where a good living year is one spent with good health, and a living year with worse health is one with reduced quality. This relation can be expressed numerically. The definition of effect is synonymous with the definition of health benefit. One white paper unsuccessfully argued for the inclusion of coping as part of the health benefit criterion (NOU 2018: 16, p. 77, p. 104). Health improvements for family members may, in relevant cases, be considered in the calculation of health benefit. *Opportunity cost* is the health benefit for other patients that could have been achieved with the same resources and is especially relevant if there are few choice alternatives. This sum is based on the average cost of a good living year based on small adjustments in health budgets and is currently set at NOK 275,000 NOK per QALY as the basis for group-level prioritization decisions. *Severity* is '(…) quantified by measuring how many good years of life will be lost by the absence of the measure under consideration, i.e. absolute shortfall' (Meld. St. 38 (2020-2021), pp. 60–61). This means that the more severe a condition is, the higher the acceptable cost-effectiveness ratio is. Horn, Barra et al. (2021) exemplify this with childhood deafness as a condition that is prioritized due to high severity; future years of hearing loss will lead to the loss of an equal number of good years of life.

The result is a numerical value that determines the worthiness of an intervention or measure and its priority compared to other measures. To be implemented, an intervention must provide more health benefit gain per unit of cost, adjusted for severity, compared to the intervention it displaces. Basic needs and care are exempt from this calculation, as these are considered fundamental and important to human dignity (Meld. St. 38 (2020-2021), pp. 68–71). Very small patient groups with severe conditions are also exempted, where a lower requirement for documentation and/or a higher resource allocation may be accepted compared to other interventions (Meld. St. 38 (2020-2021), p. 61). Preventative measures are treated differently to other interventions, as severity is accounted for at a projected future moment when it is thought that the measure will come into effect. Severity in prevention interventions is discounted at a rate of 4% per year between investment and estimated gain realization, both in terms of cost and health benefit gain (Meld. St. 38 (2020-2021), pp. 64–66). The discounting of health benefit gain was not supported by either the Norheim or the Blankholm report, but was nonetheless implemented (NOU 2014: 12; NOU 2018: 16).

The Case: Choosing Between Home Care Services, Institutions or Preventative Measures

We focus on plausible and relevant long-term political decisions on a municipal level, as these imply long-term commitment in terms of finances and future consequences. Our fictional case is *Andeby municipality*, a medium-sized municipality in the middle of Norway, with 10,000 inhabitants, an ageing demographic and a large area. The town of Andeby is the administrative centre, with roughly half of the municipal population. The municipal council is aware of the population getting older and implications towards an increase in demand for elderly care, together with a shrinking work force in the near future. This means that the talent pool from which the council can draw both tax revenue and skilled healthcare personnel will be limited and uncertain. The municipal council must prepare for the future and decide *which kind of elderly care* they will offer their inhabitants as part of their legal obligations. As the resources are limited, prioritizations must be made. Andeby sees three main realistic, non-mutually exclusive alternatives for future investments in municipal healthcare[5]. The prioritization is to rank them; no single alternative will be completely ignored. The main alternatives are as follows:

1. *Building institutions such as nursing homes*, which may be the most appropriate solution for the most ill but is resource-costly and involves risks such as insufficient public funding, staff shortages and longer waiting times for daily help in home care services.
2. *Investing in home care services*, including assisted living facilities, which is probably the most cost-effective but involves risks such as insufficient care for the most ill elderly persons.
3. *Investing in preventative public health measures*, which may delay the use of health services but involves risks such as unrealized investment, taking money away from more pressing issues, prioritizing abstract future needs over current services, and providing only a temporary and inadequate solution if preventative measures only postpone rather than decrease care needs.

Some case limitations exist. Home services encompass a range of services including home services in people's own home, home services in assisted living facilities where users are renting an apartment in a central area of the municipality, to a plus-solution with home services in assisted living facilities where the users pay rent and a premium to have 24-hour access to health personnel. The differences between home services and institutions therefore comprise a sliding continuum, with one key difference: the financial cost of home services outside necessary or basic care is mostly borne by the user (Blix & Hamran, 2019).

Discussion

Analysing the Current Priority-Setting Criteria

We found that the current priority-setting criteria are mostly inspired by utilitarianism. A strong sign is the procedural form of the priority-setting criteria, as the procedure starts with a cost/effect calculation, defining effect as a good living year according to the QALY metric. Horn, Barra et al. (2021) describe this as 'maximising healthy life years' and as a specific form of utility; it is utility with a cut-off that neglects non-health-related aspects of well-being.

5. The alternatives are chosen as we believe these alternatives are the most common way to organize elderly care in Norwegian municipalities. This is not an exhaustive list of all alternatives, but these are those that are most costly. Thanks to Mona and Katrine at USHT Troms for helping us in the design of this case.

A utilitarian cost/effect calculation can be vulnerable to the standard criticism of enabling sacrifices of underprivileged minorities (Rawls, 1999, pp. 29–30). Ottersen et al. (2014) argue that a cost-effectiveness analysis with a pure QALY maximalization does not make any reference to the worst-off and is therefore an insufficient base for priority-setting, and that prioritarian principles have support among their survey respondents and may balance out this issue. Prioritizing the worst-off is one of the three widely accepted criteria for ethical health priority-setting (Norheim, 2016). Furthermore, Ottersen et al. (2016) argue that the severity criterion incorporates a special concern for the worst-off and promotes fairness by improving the health of those with more severe illness first. Horn, Barra et al. (2021) argue that the severity criterion may conform somewhat to prioritarian ideas, but there are differences between Rawls's difference principle and the severity criterion: QALY shortfall is limited to health benefits, which is a more limited version of being underprivileged than Rawls's difference principle. Horn, Barra et al. (2021) argue that there are compelling reasons to choose a wider account of severity – for example, based on well-being.

Basic needs and care are also exempt from the cost/effect calculation for reasons related to dignity (Meld. St. 38 (2020-2021)). This can conceivably be traced to different theories from political philosophy. First, this exemption may be motivated by *sufficientarianis*m – the idea that, as moral equals, we are entitled to a certain minimum level of welfare (e.g., Shields, 2020). There is, however, no agreed exact standard for what is considered *a safe minimum* of healthcare services, especially when given a specific patient's actual situation (Tønnessen et al., 2020). The exemption of basic needs and care may also be thought of as similar, but different, to the Rawlsian difference principle to privilege the least well-off, as discussed in earlier Norwegian reports on health priority-setting, in line with the *ideals of equal access and solidarity with the vulnerable* from the 1987 white paper (Haldar et al., 2020; Hofmann, 2013; Meld. St. 38 (2020-2021)). Thirdly, exempting basic needs may also be motivated by the dignity rationale, which connects to theories of recognition and relational justice (Anderson, 1999; Fraser et al., 2003) and the Rawlsian commitment to secure the social bases of self-respect (Rawls, 1999, p. 478; Stensen, 2022, pp. 9–10); these alternatives are more closely linked to the white paper's own account (Meld. St. 38 (2020-2021), pp. 70–71). A fourth alternative is the soundness requirement, which is the lowest acceptable legal level for sound health and care services (Meld. St. 38 (2020-2021), p. 106), which may conform with sufficientarianist ideas. None of these reasons are mutually exclusive.

We argue in line with Horn, Barra et al. (2021) that the current priority-setting criteria constitute a *severity-weighted cost-effectiveness strategy* that mainly follows a maxi-average-type strategy. The dominant theory in the current priority-setting criteria is utilitarianism, in line with the arguments of Haldar et al. (2020). They are, however, modified through the severity criterion and rule exemptions originating from either Rawlsian/prioritarianist perspectives, sufficientarianism and/or a form of relational justice. A utilitarian approach weighs cost-effectiveness, and the inherent principles apply to all parts of the Norwegian healthcare system and to all levels of decision-making. However, aspects of utilitarianism may be counter to the intuitions of reasonable persons, especially in situations where the least privileged lose out. The addition of the severity criterion, which is reminiscent of a maxi-min-type principle, aims to address this.

This balancing between different positions in current priority-setting criteria is a moral pluralist approach, as argued by Norheim (2009) and Ottersen et al. (2016). We note that the current priority-setting criteria are mainly consequentialist, although the severity criterion may have deontological origins; medical staff have a long tradition of prioritizing lives, and the severity criterion may be a consequentialist answer to a deontological principle of

prioritizing to save lives[6]. The existence of both maxi-average and maxi-min principles in priority-setting criteria is theoretically inconsistent (Tännsjö, 2019). This inconsistency has also shown to cause difficulties in practice (Førland et al., 2021). The addition of the severity criterion and the following exemptions to utilitarianism can, in a Rawlsian line of argument, be criticized as the addition of ad-hoc constraints on maximizing grounded in moral intuitions (intuitionism), as there is no *one* specific unifying principle such as the Original Position behind it (Rawls, 1999, pp. 30-ff). In the following section, we argue that the current priority-setting criteria also imply some indeterminacy.

The Current Priority-Setting Criteria, Our Constructed Case and Some Indeterminacy in Political Decision-Making

The current priority-setting criteria also have implications for Andeby, whose municipal council was to choose between (1) prioritizing nursing homes, (2) prioritizing home services, and/or (3) preventative measures. Preventative measures will most likely be ranked third due to the discounting principle of both the cost and health benefit gain by 4% annually, unless that which is to be prevented is imminent or the cost/effect and/or severity is very high – for example, COVID-19. This leaves a ranking between alternative 1 and 2 under most circumstances. Sometimes, this ranking is relatively easy – for example, a young demographic may point to the prioritization of home services due to the cost/effect analysis.

While Andeby has an ageing but not very old demographic profile, weighing alternative 1 against 2 is not that easy. Andeby municipal council finds it hard to clearly decide the future cost/effect calculation by using current priority-setting criteria, as this depends on a balancing act between home services and nursing homes. The municipal council is likely not going exclude any option, but rather rank them. This could be expressed as proportions, such as 35/65, 50/50, 65/35 or other, or maybe not in numerical terms at all. The pros of prioritizing *alternative 1* are generally concerned with ensuring the taking care of the most ill, while the risk is inadequate home services. The pros of *alternative 2* are cost-effectiveness in terms of staff use and resource cost, while the risks may be severe situations where people are not moved to institutions in time and suffer at home – for example, people with severe dementia. We argue two main sources of this indeterminacy.

The first source is indeterminacy due to the complexity of services and, to some degree, the difficulty of measuring and calculation. One complication is that it is possible to provide a range and levels of service (not only binary as delivered or not) within both municipal home services and institutions, and there might not be a linear function between cost and effect, as diminishing returns may appear. The second complication is time: people live their whole lives in municipalities with varying needs for municipal healthcare over time, leading to variations in cost/effect-calculations and severity (NOU 2018: 16, p. 77).

A third complication of the cost/effect calculation checked for severity is that QALY is a limited measure of health benefit and QALY shortfall is a limited form of severity: both are disease-specific (Horn, Barra et al., 2021). As a measure, QALY has limits, as it makes no distinction between levels of utility above the threshold of a good living year, and it does not include total well-being (Horn, Barra, et al., 2021), suffering due to non-adaptation of an ill-

6. The distinction depends on whether one chooses to see the severity criterion as a mainly deontological principle used in a consequentialist manner or as a consequentialist principle with a deontological origin. The distinction may be underdetermined without further investigation, and we will not take this discussion further as the distinction is not relevant to our main argument.

ness (Jølstad, 2023), or coping (Meld. St. 38 (2020-2021), pp. 42–49; NOU 2018: 16, 2018, p. 77, p. 104). Leaving coping out of definitions of the health benefit criterion and severity also leaves out a major (legal) goal of municipal healthcare services. Further, effect of care is hard to quantify as QALYs (Horn, Jølstad et al., 2021). As such, the current definition of using QALY and QALY shortfall as metrics for health benefit and severity implies that the current priority-setting criteria may be underspecified for political priority-setting. The disease-specificness of QALY may also lead to a comparison of apples and oranges. Furthermore, there is no public, academic or professional consensus on definitions of severity. Public views on severity are sometimes conflicted and different from policy (Stenmarck et al., 2023), and severity sometimes conflicts with utilitarian thinking when prioritizing in practice (Førland et al., 2021). Finally, fewer studies have been conducted on cost and effect for interventions in municipal contexts than in hospitals (Horn, Jølstad et al., 2021). The consequence of these complications is that health benefit and severity, operationalized as QALY and QALY shortfall, may be mathematically hard (although probably not impossible) to quantify for a large and heterogenic group of people with dynamically changing needs over time.

We define the second source of indeterminacy as local factors, which are tied to specific local contexts that can skew cost/effect calculations. This is especially relevant in terms of healthcare personnel: the future national lack of access to qualified health personnel and dwindling taxpayer base are well known (NOU 2020: 15; NOU 2023: 4), but the exact local distribution is more uncertain. Another factor is local case-specific factors, such as where people live, and logistically rational solutions for both home care services and nursing homes for this geographical distribution. Thirdly, and related, the amount, location and access to homes fit for living into old age may geographically vary and depend upon local geography, property development and politics (NOU 2020: 15). A fourth factor is the pre-existence of resources, such as municipality-owned land or relevant buildings that can be utilized. The above list is not exhaustive, but the important point is that the presence of too many unknown factors may lead to indeterminacy due to underdetermination by not having the necessary information to make a viable cost/effect analysis with a subsequent decision.

Using the current priority-setting criteria in political decision-making in municipal healthcare services may also require a minimum of medical and/or health economics knowledge. A certain amount of research and/or medical documentation is plausibly needed to say anything substantial about QALY gain, loss or shortfall. According to Horn, Jølstad et al. (2021), this may be lacking in municipal contexts. Further, a certain amount of medical knowledge is plausibly needed to meaningfully interpret such documentation. This type of reasoning is criticized by Elster (2007): the aim of formal models is often to calculate the consequences of different options to determine the most rational option. The calculations are often advanced, and Elster asks whether it is fair to assume that actors such as the politicians in Andeby municipal council can properly make use of such formal models. More importantly, Elster argues that such models may be unrealistic, as social actors are ascribed too-precise perceptions of the probability of the future consequences of their actions. The fine-grained subjective probability perceptions in such models may have no subjective reality, as they are highly unstable and context-dependent. Scott (2020) argues that higher-order consequences of policy, or consequences of consequences and so forth, are hard to estimate and plan precisely in open systems. It is therefore plausible that, in practice, **indeterminacy** will exist in the case of Andeby and similar cases when using the current priority-setting criteria in political decision-making.

Narrowing the Indeterminacy: A Suggested Heuristic

No priority-setting criteria will provide answers for all allocations, and in the case of a tie, one may want to use a tie-breaker based on either secondary considerations or a lottery (Jølstad & Gustavsson, 2023). On the basis of our analysis, we suggest a heuristic tool shown in the figure below. It is based on a modified Rawlsian Original Position and may function as a tie-breaker for municipal decision-makers when using current priority-setting criteria in political deliberation ends in indeterminacy.

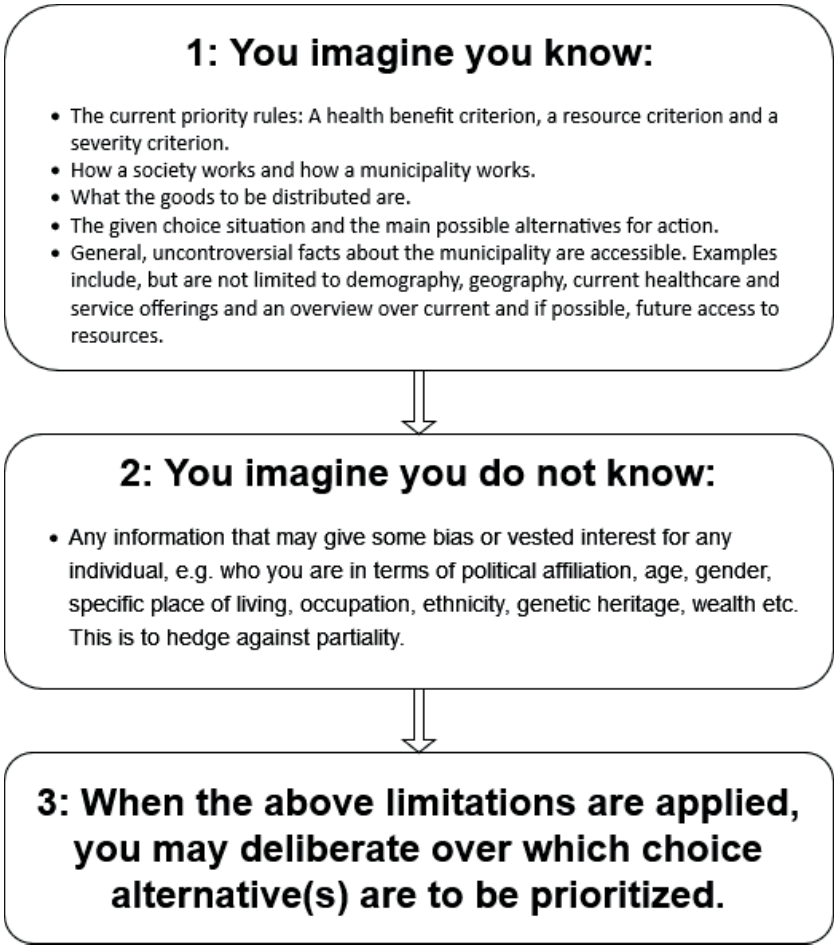

Figure 1 A Heuristic for Municipal Prioritization

We believe that this heuristic may be especially usable by municipal administration and politicians. Arguing against and suggesting an exchange of the current priority-setting criteria would not be realistic in the short term and rather useless for this paper's target group. Rawls's own principles of justice are therefore not provided as part of this heuristic. Also, the heuristic would lose some of its usefulness if it were too complicated; we criticized the current priority-setting criteria for this.

Importantly, we are not suggesting that decision-makers should engage in a full process of wide reflective equilibrium – that is, consider how a Rawlsian Original Position could model relevant background theories, make a list of firmly held moral judgements, find general principles, and so on. We are merely proposing a tool for thought: our proposed heuristic is a simplified version of Rawls' method. We ask politicians to imagine themselves being

behind a veil of ignorance in specific cases where prioritizing seems hard in order to see if this helps them make a judgement. Also, their choice is case-specific: Andeby's prioritization of option x over option y in the Original Position does not imply a *universal* rule of x > y.

We argue that our approach has several strengths. Although it falls short of a process of wide reflective equilibrium, the heuristic offers a more systematic approach than relying on moral intuitions (or gut feeling) and is based on general principles, such as impartiality, that can be thought of as fair by reasonable citizens. This impartiality exists due to symmetry between those participating in any version of the Original Position, including their symmetrical lack of bias (knowledge of who they are or represent) (Sen, 2009, pp. 56–58). The conception of impartiality that our Original Position models may be contested, but it might be more democratic than intuitionism as its definition is transparent, and its use can be subject to public scrutiny. Note that such scrutiny often takes the form of media campaigns on healthcare priorities from resourceful vested actors, which may be more vocal than other, more underprivileged groups (Figenschou et al., 2018).

Rawls's Original Position was originally designed as a procedure in an impartial situation where one may contemplate the principles of justice. However, it has several stages and was always intended to lead to practical solutions. Stage one in the Original Position is to decide general principles of justice, while stage two is to decide the constitution that can best carry out these principles. Stage three in the Original Position is to decide their legislature (Rawls, 1999, pp. 171-ff). Our heuristic is somewhat analogous to the legislative stage, but it is tailored to a more specific problem, and it does not presuppose the basic principles of justice. It may reduce indeterminacy by eliminating biased options and by being relatively simple to apply, not relying on advanced mathematical modelling.

Objections may arise. Firstly, democratically elected representatives, such as municipality councils, represent the people and should make their decisions accordingly. Philosophers should not make the choice for them. Our reply is that, whereas Rawls's Original Position may be rigged such that the parties are bound to favour Rawls's theory of justice, justice as fairness and his two principles of justice, our position is not rigged in the same way. Some council members may want to gamble a little behind the veil, others may not. This is a strength with the heuristic, as we are not determining their choice. Furthermore, it is only to be applied in situations of indeterminacy, where political discourse and the application of the current priority-setting criteria have failed to yield a clear result. It facilitates their judgement; it does not override it. Indeed, there is no judgement to override.

Secondly, arguing for the Original Position and the veil of ignorance equates to arguing for a controversial idea about impartiality. However, all ideas of impartiality are controversial. We do not argue that our version of the Original Position is the *ultimate* heuristic that a municipal council might use, but that it would be reasonably just, beneficial and democratic to use it. Also, the presence of Rawls's thinking in current policy documents, both directly referenced and as a part of prioritarian arguments in scientific literature leading up to policy documents, gives the municipality a reason to apply Rawls's framework in relevant decisions[7].

7. Rawls is mentioned 13 times in the Norheim NOU report from 2014, with most references featuring in a discussion in a specific text box (NOU 2014: 12, pp. 26–27). Rawls is not directly mentioned in the other documents, but ideas such as privileging the least well-off are observable in several places in all three documents in the data material. The two most recent documents also refer to the discussions in the Norheim report in several instances.

A third objection is inspired by Jølstad and Gustavsson (2023), who argue that if a tie between choices appears, lottery is to be preferred to secondary considerations deemed not good enough to be among the primary considerations that made up the priority-setting criteria to begin with – for example, the use of age as a criterion for vaccine distribution during COVID-19. We agree that age as tie-breaker can be seen as biased and insufficient. However, our heuristic is not a criterion, but based on Rawlsian ideas already present in the current priority-setting criteria and preceding grey papers. The motivation for holding a lottery – impartiality – is the same basis that we choose when modelling our heuristic. Furthermore, advocating for a change or replacement of the current priority-setting criteria was ruled out earlier in this text. Lastly, seemingly leaving prioritization to chance through a lottery may be perceived as politicians failing their responsibilities. A choice made in any version of the Original Position is plausibly more defendable to the public than a lottery.

Implications for Our Case

Our heuristic only offers a modified version of Rawls's Original Position, and not his principles of justice. However, we believe that certain aspects of our version of the Original Position align with the difference principle. Firstly, in our version of the Original Position, impartiality can lead to some risk aversion or a maxi-min strategy. This may not be as definite as Rawls's difference principle, but the veil of ignorance arguably limits severe gambling as one may end up as the least privileged when the veil is lifted. This addresses a weakness of utilitarianism, where underprivileged groups may be discriminated against for the greater good. Also, our version of the Original Position does not require advanced mathematical modelling; it only asks those present to decide who is the least privileged or least well-off in a choice situation. Regarding our case of Andeby, the first step would be to decide which group is the least privileged. A plausible candidate may be elderly people with dementia who live at home but need more care services than home care services are able to deliver. Given that these are the least privileged, the building and running of nursing homes may be given more weighting than under the current, utilitarian priority-setting criteria, at least until nursing home capacity is approaching the needs of this group. Here, home services may be weighted less, at least until nursing home capacity is ample. This may change if another group becomes the least privileged – for example, in a case of severe undercapacity of assisted living facilities for the mentally ill.

One drawback is that our heuristic does not guarantee a complete elimination of indeterminacy due to local factors; even if it circumvents QALY calculations, various local factors may still leave the quest of identifying the worst-off incomplete. Additional possible drawbacks are that our heuristic may lead to less cost-effectiveness than the current priority-setting criteria, and that our (or any) version of the Original Position is designed for decision-making in the political-administrative field and is probably unfit for decisions on a clinical level[8].

8. A lack of cost-effectiveness is not an obvious drawback. Rawls argues that '[w]hereas the utilitarian extends to society the principle of choice for one man, justice as fairness (…) assumes that the principles of social choice (…) are themselves the object of an original agreement. There is no reason to suppose that the principles which should regulate an association of men is simply an extension of the principle of choice for one man' (Rawls, 1999, p. 25). Also, the inadequacy of the Original Position for clinical decisions may not actually be a drawback; we have argued earlier in the text and in this endnote that different methods may be appropriate for different contexts, notwithstanding considerations of parsimony.

Conclusion

The current priority-setting criteria for healthcare services in municipalities express a cost-effectiveness strategy that considers severity, resembling a maxi-average strategy. It has a utilitarian foundation but is modified by severity to address its weaknesses. The severity criterion and exemption of basic care prioritize the least well-off, and while the origins of the severity criterion may be deontological, it conforms with Rawls's difference principle, self-respect, sufficientarianism, and relational justice perspectives such as dignity and recognition. As such, it follows a moral pluralist approach. However, using the current priority-setting criteria can lead to indeterminacy in municipal political decision-making due to complexity or local factors. To address this, our heuristic tool based on Rawls's Original Position can be used; both model impartiality, and, with it, some risk aversion towards the worst outcome.

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