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SEARCHING FOR A FAIR ALLOCATION OF SCARCE MEDICAL RESOURCES UNDER EU LAW: A NEED FOR BALANCE FOR THE ELDERLY?♦

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Abstract

Fair allocation of scarce medical resources during emergency situations such as the COVID-19 pandemic is a highly challenging task. The pandemic has revealed that age was invoked as a criterion in terms of granting access to medical treatment in some European Union countries such as Italy. This paper analyses whether or not the use of chronological age alone might be justified for any such differential treatment in the event of scarcity. The paper seeks to demonstrate that older persons should not be automatically excluded from receiving access to healthcare which might otherwise amount to direct discrimination under European Union law.

Keywords: *Age Discrimination, Scarce Medical Resources, Old Persons, COVID-19 pandemic, European Union Law.*

AB Hukukunda Kısıtlı Tıbbi Kaynakların Adil Dağıtımı Arayışı: Yaşlılar için Bir Denge İhtiyacı?

Öz

Kovid-19 pandemisi gibi acil durumlarda sınırlı tıbbi kaynakların adil şekilde dağıtımı, oldukça zor bir görevdir. Pandemi sürecinde, yaşın İtalya gibi bazı Avrupa Birliği ülkelerinde tıbbi tedaviye erişim bakımından bir kriter olarak kullanıldığı görülmüştür. Bu çalışmada, kaynakların yetersiz olduğu durumlarda, kronolojik olarak yaşın tek başına kullanılmasının, bu tür farklı işlemler bakımından haklı şekilde gerekçelendirilip gerekçelendirilemeyeceği hususu incelenmektedir.

♦ An earlier version of this paper was presented at Berkeley Centre on Comparative Equality and Anti-Discrimination Law Annual Conference in 2021.

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Çalışmada yaşlı kişilerin, tıbbi tedaviye erişmekten kendiliğinden dışlanmaları durumunun, Avrupa Birliği Hukuku çerçevesinde doğrudan ayrımcılığa yol açabileceği tartışılmaktadır.

Anahtar Kelimeler: *Yaşa Dayalı Ayrımcılık, Sınırlı Tıbbi Kaynaklar, Yaşlı Kişiler, KOVİD-19 pandemisi, Avrupa Birliği Hukuku.*

Introduction

Covid-19 pandemic is an unprecedented catastrophic incident and a public health emergency which has severely hit the whole world. Still, the long-lasting effects of the pandemic are experienced in daily lives of many individuals. However, the pandemic hit older persons the worst due to their fragile health conditions which led to high amounts of loss among them. The pandemic caught health care systems of several countries severely unprepared and hands-tied. It led to irreversible consequences for some part of older persons.

When the pandemic hit the European continent, particular attention was paid to Italy where the doctors were urged to make a choice between saving the lives of either the younger or older patients due to the scarcity of medical resources. The introduction of some ethical allocation principles which determines on how these resources shall be distributed among patients is an extremely difficult task at emergency times. Hence, the pandemic revealed the difficulty in reaching a fair balance between the public benefit maximized for all and the individual benefit focusing on a personal well-being. Under EU law, the EU is given a limited and supportive role within human health protection. Yet, the pandemic also showed the need for the EU to intervene in this process in line with the principle of subsidiarity.

This paper focuses on the use of chronological age as a determinant in terms of the allocation of scarce medical resources and examines whether or not any such practices might amount to age discrimination under EU law. It's seen that this topic is rather examined in the literature through the lens of Bioethics and by scholars specialized in this field. Given that the legal perspective has received less attention, the novelty of this study is in its effort to come up with a combination of both legal and ethical approaches and thus to contribute to the literature. The approach chosen in this study is largely based on a comprehensive literature review which is strengthened through an analysis of the legal norms under EU law. Departing from these considerations, the paper starts by giving a brief background of the legal

norms related to age discrimination and the right to health under EU law. This is followed by a detailed review of resource allocation criteria invoked during public health emergencies. Then the core part of the paper shall try to analyze whether or not the exclusion of old persons from the allocation of scarce medical resources amounts to age discrimination and whether or not these practices can be legitimately justified. The paper argues that the chronological age alone shall not be taken as a reference in decisions with regard to the allocation of limited resources since this approach excludes the elderly people in receiving an adequate treatment. Rather the determinant criteria shall be based on need regardless of age as advocated by several scholars from the Gerontology societies. Therefore, this paper tries to demonstrate that old persons are discriminated against when they are considered collectively as a homogenous group of people rather than being treated on the basis of their diverse and individual conditions. Yet, this issue is of critical significance in terms of the introduction of a regional health priority setting at the EU level.

I. The Legal Definition of Age Discrimination

It's noteworthy that discrimination on grounds of age has not been defined under instruments related to either the International Labour Organization (ILO) or the Council of Europe. The ILO adopted the Older Workers Recommendation in 1980. However, the Recommendation does not cover any definition for older workers. Rather, it urges the Member States to take all the necessary measures in terms of their national policies and rules to combat discrimination in employment and occupation against older workers.[1]

Age discrimination occurs when a person is subjected to a less advantageous treatment than another comparable person in the same or a similar condition only on grounds of his or her age. The scope of legal rules and policies which prohibit age discrimination cover persons of all ages. Yet, in practice it's rather the older persons who are more exposed to differential practices based on age. Age discrimination might take place either on a direct or indirect discriminatory basis. According to Drury, direct age discrimination covers '*the use of specific age limits to exclude older workers or older job-seekers from employment, recruitment processes or from*

[1] Gözde Kaya, "EU Age Discrimination in Light of EU's Demographic Challenges and ECJ Case Law", *Dokuz Eylül Üniversitesi Hukuk Fakültesi Dergisi*, 17, no 1 (2015): 85-86.

employment measures such as re-training.'[2] On the other hand, indirect discrimination occurs in implicit form and encompasses *'measures which are not directly age-specific but which have a negative impact on older workers'* as in the case of state-subsidized pre-retirement allowances or invitations of voluntary redundancy directed to workers over a certain age.[3]

II. The Legal Framework Related to the Prohibition of Age Discrimination under EU Law

The legal base of the prohibition of age discrimination finds its place under Article 19 TFEU which lays down a general principle of non-discrimination. Article 19 TFEU gives the Council the competence to take the necessary measures to combat discrimination based on numerous grounds covering sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation.[4] This article lays down the general principle of non-discrimination under EU Law within a closed-list. Several prohibited grounds of discrimination are mentioned here, and age is one of these grounds.

A further provision to note is Article 10 TFEU which is regarded as the general mainstreaming article. Article 10 TFEU imposes an obligation on the EU to combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation when the Union defines and implements all its policies and activities.

The prohibition of age discrimination is also formulated under the relevant provisions of the EU Charter of Fundamental Rights. The Charter regulates the ban on age discrimination under Article 21 which sets forth and prohibits many other grounds of discrimination besides age. Article 21 of the Charter lists these prohibited grounds of discrimination within a non-exhaustive list unlike Article 19 TFEU. Moreover, Article 25 of the Charter ensures the rights of the elderly to pursue a life of dignity and to participate in social and cultural life. This is further accompanied by Article 34/1 of the

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[2] Elizabeth Drury, "Age Discrimination Against Older Workers in the European Union", *The Geneva Papers on Risk and Insurance-Issues and Practice* 19, no.73, (1994): 497; Gözde Kaya, "Age Discrimination as a Bone of Contention in the EU", in *The European Union as Protector and Promoter of Equality*, ed. Thomas Giegerich, (Switzerland: Springer, 2020), 395.

[3] Drury, "Age Discrimination", 497; Kaya, "Age Discrimination as a Bone of Contention", 395.

[4] Kaya, "Age Discrimination as a Bone of Contention", 395-396.

Charter which imposes a duty on the Union to recognize and respect the entitlement to social security benefits and social services of several disadvantageous groups covering old age individuals.

Under secondary sources, age discrimination is laid down under the Directive 2000/78[5] which covers other discrimination grounds as well. Yet, Article 6 of the Directive sets forth a specific exception for age and gives the Member States a room for pursuing a differential treatment against old age persons as long as they legitimize their conduct. The Member States are required to justify their differential practice objectively and reasonably towards achieving a legitimate aim which might concern that country's national employment policy, labour market and vocational training objectives. Besides, the means of achieving that aim have to be appropriate and necessary in line with the principle of proportionality.

However, one has to note that the protection provided by EU law against age discrimination is only limited to the labour market field. It will not be wrong to state that EU law currently is lacking a protection mechanism against any differential treatment based on age outside matters of employment or occupation. The ECJ decided in *Kaltoft* [6]case that the protection provided by the Directive 2000/78 should 'not be extended by analogy' to cover other discrimination grounds such as obesity which were not listed exhaustively among the ones laid down under Article 1. Yet, this means that age discrimination is not protected under EU law outside of the labour market context[7] such as healthcare. It's interesting to note that the European Commission indeed proposed a Council Directive[8] in 2008 which aims to extend the protection against discrimination on grounds of religion or belief, disability, age or sexual orientation beyond the labour market field. Yet, it has still been under discussion in the Council.

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[5] Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation, OJ L 303, 2.12.2000.

[6] Case C-354/13, *FOA, acting on behalf of Karsten Kaltoft v Kommunernes Landsforening (KL), acting on behalf of Billund Kommune,* OJ C 65, 23.2.2015.

[7] Elaine Dewhurst, Age Discrimination outside the Employment Field, European Network of Legal Experts in Gender Equality and Non-discrimination, European Commission, Directorate-General for Justice and Consumers, (2020), 9 and 12.

[8] Proposal for a Council Directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation {SEC(2008)2180} {SEC(2008)2181} COM/2008/0426 final, CNS 2008/0140.

III. The Legal Framework related to Right to Health under EU Law

Public health as a policy field was added to the EU's institutional structure within the Maastricht Treaty of 1992. Despite its narrowly defined scope, it still created a legal basis for the Union to adopt further legal instruments and policy measures in this area. The following Treaty amendments continued to enhance the role of the EU on a gradual basis through granting it a more active role. However, the Member States chose to retain the national competences within their own hands in terms of their health policies. Hence, it's significant to note that the initial responsibility for the health protection and healthcare systems belongs to the Member States. Yet, the EU has been granted a significant role in improving public health, preventing, and managing diseases and epidemics and a unificatory task in harmonizing health strategies of its members.[9]

That's why protection of public health is not mentioned among the areas listed under Article 3 TFEU where the EU holds exclusive competence. Protection of health is laid down under Article 6 TFEU where the EU is given a rather supportive role. According to Article 6(a) TFEU, the EU is granted the competence to carry out actions, coordinate or supplement the actions of the Member States in terms of the protection and improvement of human health.

Particular attention has to be given to Article 168 TFEU which is formulated under the Title XIV of the TFEU entitled as 'Public Health'. Article 168 TFEU is the major provision that lays down the competence of the EU in terms of the protection of human health. Under this article, the EU has committed to guarantee a high level of human health protection within the definition and implementation of all its policies and activities. The complementary role of the Union in supporting national health policies of the Member States is reiterated within the wording of this article. Furthermore, the Union has undertaken the role to encourage cooperation between the Member States particularly in terms of health services provided in cross-border areas and support their action under cases of necessity. (Art. 168/2 TFEU)

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[9] Christian Kurrer, Public Health, Fact Sheets on the European Union, European Parliament, March 2021. Accessed: 12 March 2022, europarl.europa.eu/factsheets/en/sheet/49/public-health.

Yet, in terms of the scope of this study, paragraph 7 of Article 168 TFEU is highly significant which reads as:

“Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organization and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them…”

So this provision is to be read as a clear statement of the application of the principle of subsidiarity in the health field since it draws the line between the Union’s and the Member States’ responsibilities in the protection of human health. In other words, it limits the EU’s intervention in the allocation of the medical resources assigned to the Member States.

Given this framework, it is sufficiently clear that the power of the EU is highly limited in terms of reaching the public health objectives. The Union is granted the authority to take binding action only in the areas related to the quality and safety standards for substances of human origin, blood and blood derivatives as formulated under Article 168/4 TFEU.[10]

Under the primary legal framework of the EU, one also has to mention the articles related to the right to life and the health care as laid down under the EU Charter of Fundamental Rights. Yet Article 2 of the Charter under the title of ‘Right to Life’ reads as: *“Everyone has the right to life.”* This is further strengthened by Article 35 of the Charter which is related to health care.

Another significant document worth to mention is the European Charter of Patients’ Rights[11] adopted in Rome in 2002 which is a non-binding document produced by some activists and citizens’ organizations from the Member States. It heavily relies on the EU Charter of Fundamental Rights in terms of the protection of patients’ rights and is taken into serious consideration by the Member States shortly after its publication.[12] The

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[10] Scott L. Greer, et al. Everything you always wanted to know about the European Union health policies but were afraid to ask, European Observatory on Health Systems and Policies, (United Kingdom, World Health Organization, 2014), 20.

[11] European Charter of Patients’ Rights was adopted in Rome, in November 2022. Full text, Accessed: 10 April 2022, https://ec.europa.eu/health/ph_overview/co_operation/mobility/docs/health_services_co108_en.pdf.

[12] Özge Emre and Gürkan Sert, “Avrupa Hasta Hakları Şartı”, *Türkiye Biyoetik Dergisi*, 1, no.4 (2014): 199-200.

document precisely tells in its Preamble that: *"Financial constraints, however justified, cannot legitimize denying or compromising patients' rights."* Moreover, the Charter of Patients' Rights puts an emphasis on Article 35 of the EU Charter of Fundamental Rights and requires the Member States to make their best efforts to go beyond minimum standards in terms of health protection.

IV. An Analysis on the Determination of Criteria according to which Scarce Medical Resources shall be Distributed During Extraordinary Circumstances

Covid-19 pandemic is an unprecedented catastrophic circumstance which has hit the whole world countries. The Covid-19 disease emerged in Wuhan, China in December 2019 and spread to all over China and the rest of the world.[13] When the pandemic reached the EU territory, it hit the worst the wealthiest region Lombardy within northern Italy.[14] One of the earliest calls in terms of the international protection of human rights came from the United Nations (UN) Human Rights Experts who declared in March 2020 that:

"Everyone without exception has the right to life-saving interventions and this responsibility lies with the government. The scarcity of resources or the use of public or private insurance schemes should never be a justification to discriminate against certain groups of patients."[15]

In early April 2020, the European Commissioner for Equality, issued a statement which made a reference to the UN Human Rights Experts' Declaration and provided that any decision to deprioritize or refuse any medical treatment should be based on objective ethical guidelines. The

[13] Hengbo Zhu, et al., "The Novel Coronavirus Outbreak in Wuhan, China", Short Report, Global Health Research and Policy, 5:6, (2020) 1, Accessed: 10 May 2022, https://ghrp.biomedcentral.com/track/pdf/10.1186/s41256-020-00135-6.pdf. doi: 10.1186/s41256-020-00135-6.

[14] Angela Giuffrida, "Why Lombardy was hit harder than Italy's other regions?", *The Guardian*, May 29 2020, Accessed: 20 July 2022, https://www.theguardian.com/world/2020/may/29/why-was-lombardy-hit-harder-covid-19-than-italys-other-regions.

[15] "No exceptions with Covid-19: 'Everyone has the right to life-saving interventions' – UN Experts say", UN Human Rights Office of the High Commissioner, March 26 2020, Geneva, Accessed: 27 May 2022, https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=25746&LangID=E.

statement explicitly emphasized that older persons should not be deprioritized from receiving medical or any other type of care merely on the grounds of their age.[16] This was immediately followed by a letter delivered by the three EU Commissioners[17] to the Member States. The letter asked the Member States to show significant attention to the vulnerable groups particularly the older persons in terms of providing healthcare treatment due to Covid-19.[18] This clearly indicates that the Commission -as the guardian of the EU Treaties- has urged the Member States to treat everyone equally within the delivery of healthcare services during the pandemic.

One of the most difficult decisions during a pandemic relates to the issue of how to distribute the scarce medical resources such as testing, ICU beds, ventilators, therapeutics and vaccines among the Covid-19 patients and whom to treat first. This challenging task concerns the application of some ethical allocation principles in times when 'the needs go beyond the available resources'.[19] Indeed, health care systems have very limited experiences on how to allocate scarce medical resources during a severe pandemic. Yet, there is a strong need for a pre-incident planning before such a crisis hits the hospitals.[20]

Therefore, some allocation guidelines need to be produced relying on some significant ethical values and recommendations which shall also be open to public for transparency and fairness. Yet, the introduction of these guidelines are also expected to reduce the pressure on individual physicians when they are delivering their decisions on whom to give priority.[21]

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[16] Statement of the European Commissioner for Equality, Helena Dalli on 'Covid-19 and older people', April 2 2020, Accessed: 10 June 2022; https://www.age-platform.eu/sites/default/files/Covid-19_%26_olderPeople-Dalli_statement-Apr20.pdf.

[17] These are: the Commissioner for Equality, The Commissioner for Jobs and Social Rights and the Commissioner for Health and Food Safety.

[18] The Letter of the three EU Commissioners to the Member States, April 8 2020, Accessed: 11 June 2022, https://www.age-platform.eu/sites/default/files/COVID-19-EUCommission_letter_to_Ministers_Apr20.pdf

[19] Anita Zeneli, et al. "Identifying ethical values for guiding triage decisions during the COVID-19 pandemic: an Italian ethical committee perspective using Delphi methodology", *BMJ Open,* 11, (May 18, 2021): 2, Accessed: 16 June 2022, https://bmjopen.bmj.com/content/11/5/e043239.

[20] Mary-Elise Manuell, et al., "Pandemic Influenza: Implications for Preparation and Delivery of Critical Care Services", *J. Intensive Care Med*., 26, no.6 (2011):15.

[21] Ezekiel J. Emanuel, et al. "Fair Allocation of Scarce Medical Resources in the Time of Covid-19", *The New England Journal of Medicine,* 382, no. 21, (May 21 2020): 2054; Manuell et al., Pandemic Influenza, 17.

A. SIAARTI Guidelines

There have been many bioethical discussions on this issue both before and during the Covid-19 pandemic.[22] Several ethical bodies as well as medical physicians have introduced some principles on how this allocation might be offered. It's seen that utilitarianism which emerges as an effective moral theory has been invoked and criticized in terms of how the pandemic was dealt with in many countries.[23] According to utilitarianism the right action one has to take is the one which results in the greatest benefit. In other words, one has to seek the possibility that maximizes what is good for the whole society.[24]

The allocation criteria which were introduced by the Italian Scientific Society of Anesthesia, Analgesia, Resuscitation and Intensive Care (SIAARTI) in March 2020 led to a hot debate on this issue. SIAARTI guidelines/recommendations were introduced on an ad-hoc basis within a 'soft utilitarian' approach. These guidelines aim both to share the responsibility in the decision-making processes of the individual medical physicians and to introduce some common criteria for the allocation of scarce medical resources.[25]

SIAARTI guidelines and particularly the criteria for ICU admission are based on the principle of distributive justice and appropriate allocation of limited healthcare resources among the other principles of clinical appropriateness and proportionality of care.[26] The guidelines exclude the egalitarian 'first come first served' approach in terms of the extraordinary pandemic processes which in principle is conducted in normal situations.[27]

What raised a tension in terms of SIAARTI guidelines is that age is regarded as a possible indicator for excluding some patients from receiving access to scarce medical resources such as mechanical ventilators or ICU

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22 Zeneli et al, "Identifying ethical values", 2.

23 Julian Savulescu, et al., "Utilitarianism and the pandemic, *Bioethics,* 34, no.6, (2020): 620.

24 Savulescu, et al. "Utilitarianism", 620-621; Nicholas Buck, "COVID-19 and the Limits of Utilitarianism", June 11 2020, Accessed: 17 June 2022, https://divinity.uchicago.edu/sightings/articles/covid-19-and-limits-utilitarianism.

25 Marco Vergano, et al. "SIAARTI recommendations for the allocation of intensive care treatments in exceptional, resource-limited circumstances", *Minerva Anestesiologica* 86, no.5, (2020 May): 470, doi: 10.23736/S0375-9393.20.14619-4.

26 Marco Vergano, et al. "Clinical ethics recommendations for the allocation of intensive care treatments in exceptional, resource-limited circumstances: the Italian Perspective during the Covid-19 epidemic", *Critical Care*, 24, no.165, (2020): 1.

27 Vergano et al., "SIAARTI recommendations", 470.

beds.[28] The guidelines precisely provide that *"an age limit for the admission to the ICU may ultimately be set. The underlying principle would be to save limited resources which may become extremely scarce for those who have a much greater probability of survival and life expectancy, in order to maximize the benefits for the largest number of people."*[29] Yet, the guidelines suggest providing the therapeutic treatment to patients with greater chances of life expectancy. Besides age, healthcare professionals were needed to carefully assess the severity of the disease, the functional status and the existing comorbidities of each severely ill patient. According to this approach, the elderly and fragile patients with severe comorbidities might consume the scarce medical resources for a longer period in comparison to younger and potentially less sick patients. Hence, a decision to deny these scarce resources to some patients might ultimately be justified under these overwhelming conditions.[30] This situation is also resembled to that of a war time.[31]

However, shortly after the SIAARTI guidelines, the Italian National Bioethical Council introduced a document which this time argued in favour of personalization of care and clinical appropriateness as the key principles to be guided.[32] Yet, the introduction of an age criterion has led to significant criticisms among several scholars.

B. Allocation Criteria Recommended by Other Scholars

Before elaborating further on these critics, it's better to primarily concentrate on what other scholars suggest in terms of the guiding principles and values for the allocation of scarce resources. There are some commonly agreed principles which have been referred to by several scholars within their works. Based on their research, Emanuel et al. draw four set of common ethical values for the allocation of scarce resources. These four fundamental values are listed as: *'maximizing the benefits produced by scarce resources, treating people equally, promoting and rewarding instrumental value, and giving priority to the worst off'*. Departing from these values, six set of recommendations are offered which could be

[28] Zeneli et al, "Identifying ethical values", 2.

[29] Vergano et al. "SIAARTI recommendations", 471.

[30] Ibid.

[31] Erica Di Blasi, "Italians over 80 'will be left to die' as country overwhelmed by coronavirus", *The Telegraph*, March 14 2020, Accessed: 19 June 2022, https://www.telegraph.co.uk/news/2020/03/14/italians-80-will-left-die-country-overwhelmed-coronavirus.

[32] Zeneli et al., "Identifying ethical values", 2.

supportive in introducing a fair allocation of scarce medical resources.[33] Other scholars for instance Zeneli et al. introduce similar guidelines through employing a Delphi methodology.[34]

One of these recommendations includes the 'value of maximizing the benefits' which means saving the highest number of lives or saving the patients who are likely to survive for longer years after receiving the treatment.[35] White and Lo support this value by setting a precedent from the US legal system. They emphasize that a patient's projected survival of years is taken into consideration when deciding for his/her suitability for a lung transplantation in the US.[36] There is a consensus among the experts in terms of accepting this value as one of the leading principles.[37] A study conducted by Biddison et al. also supports and lists these as *"first"* or *"foundational"* principles for triage decisions.[38] Zeneli et al. advocate that this value is better to be combined with other principles in order to reduce the negative effects of a purely utilitarian approach on disadvantaged people.[39] Otherwise such an approach alone is risky to jeopardize individual rights and freedoms particularly in terms of the principle of autonomy which might conflict with the overall good.[40]

Another recommendation proposes that the scarce medical resources should first be provided to the front line health professionals who face this risk to the highest level and who are also more difficult to be replaced in terms of their training.[41] This has been supported by others who argue that prioritizing the health care workers is also in line with the principle of reciprocity since they risk their lives for treating others.[42] This will also mean that they can return saving other lives much sooner than otherwise.[43]

33 Emanuel et al., "Fair Allocation", 2051.
34 Zeneli et al., "Identifying ethical values", 1-10.
35 Emanuel et al., "Fair Allocation", 2051.
36 Douglas B. White and Bernard Lo, "A Framework for Rationing Ventilators and Critical Care Beds During the Covid-19 Pandemic", *JAMA,* 323 no.18, (March 27 2020): 1773.
37 Emanuel et al., "Fair Allocation", 2052; Zeneli et al., "Identifying ethical values", 6-7; Vergano et al., "SIAARTI recommendations", 471.
38 Elizabeth Lee Daugherty Biddison, et al., "Scarce Resource Allocation during Disasters: A Mixed-Method Community Engagement Study", *CHEST,* (2017): 12, doi.org/10.1016/j.chest.2017.08.001.
39 Zeneli et al., "Identifying ethical values", 6.
40 Savulescu et al., "Utilitarianism", 621.
41 Emanuel et al, "Fair Allocation", 2053. Giving priority to health professionals is also referred to as the 'instrumental value' in the literature.
42 White and Lo, "A Framework for Rationing Ventilators", 1774.
43 Savulescu et al., "Utilitarianism", 625

However, some scholars think that this value needs to be further clarified at the societal level and to be supported on a wider basis to be safely adopted.[44]

Scholars commonly agree that patients with similar prognosis should be treated on an equal basis through a random allocation such as running a lottery. Jansen and Wall suggest employing a weighted lottery which would give everyone an equal chance and avoid any kind of discrimination.[45] Patients are not recommended to be treated on a first come first served basis since this would put the latter category into a considerably disadvantageous position.[46] Zeneli et. al., also accept lottery as a preferable guideline within their research.[47]

The worst-off value which is commonly approved by scholars as an allocation principle requires particular attention. It is perceived as giving priority to either the younger patients or the sickest ones.[48] White and Lo advocate that younger patients should be given priority since yet they have not passed and completed the different stages of a life journey in terms of the principle of 'life cycle'.[49] This principle -as a principle of justice- requires that every individual should be given the same opportunity to live the cycles of a standard life such as childhood, young-adulthood, middle-age and old-age.[50] It is also referred to as the 'fair innings argument' or 'intergenerational equity'.[51]

Examples to other allocation principles can be the listed as the principles of transparency, equity and reciprocity (being awarded on the basis of societal merits).[52] Scholars commonly agree that fair allocation necessitates the adoption of a multi-value ethical framework even though there is short time for handling these complicated algorithms within a public health emergency. The reason is that no ethical value is yet sufficient alone to determine which patients should be provided with these scarce resources.[53]

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[44] Zeneli et. al., "Identifying ethical values", 7-8.
[45] Lynn A. Jansen and Steven Wall, "Weighted Lotteries and the Allocation of Scarce Medications for Covid-19", *Hastings Center Report*, 51, no.1, (2021): 39-46.
[46] Emanuel et al, "Fair Allocation", 2053.
[47] Zeneli et. al., "Identifying ethical values", 8.
[48] Emanuel et al, "Fair Allocation", 2051.
[49] White and Lo, "A Framework for Rationing Ventilators", 1773.
[50] Zeneli et. al., "Identifying ethical values",7; Douglas B. White, et al., "Who Should Receive Life Support During a Public Health Emergency? Using Ethical Principles to Improve Allocation Decisions", *Ann Intern Med*., 150, no.2, 2009: 136.
[51] White et al, "Who Should Receive Life Support", 136.
[52] Zeneli, et al., "Identifying ethical values", 3-8.
[53] White and Lo, "A Framework for Rationing Ventilators", 1774; Emanuel et al, "Fair Allocation", 2051; White et al., "Who Should Receive Life Support", 137.

C. The Debate around Age Criterion

The current pandemic and the SIAARTI guidelines led the scholars to revisit the long-lasting debates as to whether age should be taken as a determining criterion within the allocation of scarce medical resources. There is still a lack of clear consensus in the literature on this issue. The scholars are divided into two categories in terms of that open question.

Piazza strongly advocates that age alone should not be taken as a key factor in determining whether or not a patient is to be given access to intensive care or such similar treatment practices. According to her, age cannot be considered as a reliable and sufficient indicator to show how a patient is to respond to treatment. She accepts that some elderly patients with some severe comorbidities might have a low chance of survival even if they are given access to intensive care. However, a healthy 75-year-old patient cannot be prevented from access to treatment relying on the age criterion alone.[54]

Archard agrees that age shall not serve as a criterion for this allocation. According to him, age is used because it might serve as an indicator of some differences such as clinical frailty, likelihood of survival or the projection of fewer years following the treatment. However, using age seems to be unreliable and is also likely to lead to differential treatment against old people.[55] Hence linking age with comorbidities and fewer years of life remaining might lead to categorization of all older people and penalizing healthy older individuals.[56] Brown and Goodwin also argue that allocation guidelines which prioritize younger patients over older ones with similar prognosis, are often leading to implicit discriminatory practices based on social prejudices.[57]

Piazza states that the introduction of an age criterion which focuses on the clinical frailty scale of patients over 65 for access to intensive care as formulated under the British Guidelines of the National Institute of Health and Care Excellence (NICE) of April 2020, are not suitable in terms of ethical and legal considerations. She regards these practices to be ‘defensive

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[54] Ornello Piazza, “Saving Limited Resources During Covid-19 Pandemic”, *Translational Medicine*, 23, no.4, (2020): 20.

[55] Dave Archard, et al, “Is it wrong to prioritise younger patients with Covid-19?”, *BMJ,* 369, (2020): 1.

[56] White et al., “Who Should Receive Life Support”, 138.

[57] Matthew J. Brown and J. Justin Goodwin, Correspondence, “Allocating Medical Resources in the Time of Covid-19”, *The New England Journal of Medicine*, 382, no. 22, (2020): E79(1).

instruments' exercised by yet inexperienced physicians. According to her, the decisions should instead be based on clinical criteria linked to therapeutic consequences rather than differential treatment in terms of individual lives which could otherwise amount to age discrimination.[58]

Zeneli et al. also consider age as being discriminatory and an unsound indicator in terms of the assessment of health situation and life expectancy.[59] White and Lo, suggest that the exclusion of a certain category of patients in terms of the allocation criteria, is also likely to contradict with the principle of public health ethics. This principle requires health professionals to apply the instruments that are the least restrictive to individual liberty while pursuing a public health goal at a collective level. Yet, a legitimate public health goal can be achieved by less restrictive measures in terms of the principle of proportionality.[60]

On the other side, there are scholars who suggest that age can be invoked as a criterion for the allocation of scarce medical resources. According to Harris, if one assumes that a reasonable life is composed of seventy years, then the ones who have already reached it, are not likely to suffer any injustice since the extra years could be regarded as a bonus. However, the ones who are exposed to dying before the age of seventy, are deprived of having lived the entire cycles of their lives. Relying on the fair innings argument, Harris argues that the opportunity to continue living should be provided to the ones which has not had a fair innings. Because otherwise a further injustice might emerge.[61] Biddison supports this by suggesting that under circumstances which patients receive equal priority in terms of other criteria, priority should be given to younger patients.[62] Jaziri and Alnahdi also stress that depriving older patients from scarce resources is ethically justifiable, yet they should be informed about this situation already before their admission to the particular hospital or unit.[63]

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[58] Piazza, "Saving Limited Resources", 20.

[59] Zeneli et. al., "Identifying ethical values", 7.

[60] White and Lo, "A Framework for Rationing Ventilators", 1773.

[61] John Harris, *The Value of Life, An Introduction to Medical Ethics*, (London: Routledge, 1985), 87-102.

[62] E. Lee Daugherty Biddison, et al. "Too Many Patients…A Framework to Guide Statewide Allocation of Scarce Mechanical Ventilation During Disasters", *CHEST,* 155, no.4, (2019): 851.

[63] R. Jaziri and S. Alnahdi, "Choosing which COVID-19 patient to save? The ethical triage and rationing dilemma", *Ethics, Medicine and Public Health,* 15, (2020): 6.

Caplan argues that elderly people, people with disabilities or from ethnic minorities have already been facing discrimination in terms of several other areas. He points out to existing medical practices in some countries such as granting access to renal dialysis only to patients below the age of 65 or limiting the possibility of a solid organ transplant for patients over the age of 80. He suggests that the use of age as a criterion under scarcity situations can be justified relying on both fair innings argument and the principle of maximizing the number of lives saved since older age is likely to lead to a less chance of survival. He supports the view that *"Ageism has no place in rationing, but age may."*[64]

According to Savulescu et al. pandemics such as the Covid-19 should be led by a utilitarian approach rather than an egalitarian one. Considering the age as a measure of length, the scholars advocate that it is not the age that matters, instead it's the assumed length of the benefit which is decisive under such severe circumstances. That's why, they argue that a utilitarian approach does not lead to any discriminatory treatment against older persons and is not ageist in ethical context.[65] However, they also point out to the need that it has to be approached cautiously since it is open to misuse.[66]

A recent study carried out by Antoniou and colleagues which covers a survey conducted among a group of old age persons during the Covid-19 pandemic reveals interesting outcomes. The respondents shifted from a more individualistic approach to a utilitarian one in the context of healthcare policy. This shows that even the old persons themselves accept that the treatment priority should be provided to the younger persons during scarcity situations. According to Antoniou et al., health care professionals are not holding any intentions to breach any personal rights when they favor the treatment of younger patients in the first place.[67]

In line with that, Browning and Veit offer that the utilitarian approach is the most efficient one to be exercised during pandemics. According to them, utilitarianism is interpreted mistakenly which leads to unjust criticisms among some scholars. Yet utilitarianism inherently relies on the egalitarian principles which gives equal consideration to everyone's benefits. They argue that even the scholars who favor egalitarian principles, also bring

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[64] Archard, et al., "Is it wrong to prioritise younger patients", 2.

[65] Savulescu et al., "Utilitarianism", 620-623.

[66] Ibid, 625.

[67] Rea Antoniou, et al, "Reduced utilitarian willingness to violate personal rights during the COVİD-19 pandemic", *PLoS ONE* 16, no.10, (2021):1-14. Accessed: 18 August 2022, http://doi.org/10.1371/journal.pone.0259110.

forward utilitarian principles such as allowing for triage decisions which consider the survival possibility of patients. Otherwise a pure egalitarian approach would require full equality between the patients irrespective of their chance of survival.[68]

Choosing age as a criterion and relying on a fair innings argument also receive criticisms by some scholars. Archard argues that there is no consensus on the definition of a fair innings since luck and conditions formulate peoples' lives. According to him, an old individual who has had his/her fair innings might still contribute to the society more than a younger person who has not that much to offer.[69] Rivlin advocates that it is not easy to define fairness in terms of health care matters since it is only linked to the length of life. Would it be fair if a young person who had already received a large part of medical resources due to his anti-social attitudes, would be given priority over an old person who has lived a very responsible life and so far has not consumed any resources? Hence, Rivlin suggests that it would be unfair to treat all older persons the same way while only some might be using more resources, or some might have less years to live. Instead, older persons should be assessed on an individual basis in terms of denial of health care.[70]

D. Finding the Right Balance between Utilitarian and Non-utilitarian Approaches

The Covid-19 pandemic revealed the tension between the need to prioritize the well-being of individual patients and the public health policies which concentrate on the greater good for the highest number of patients. It seems that the public side has overweighted the individual side[71] when one examines how the pandemic was handled in most countries. According to Browning and Veit, the pandemic has further shown that a utilitarian approach which covers a cost-benefit analysis, produces better outcomes rather than a non-utilitarian one. Yet, a non-utilitarian approach focusing on

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[68] Heather Browning and Walter Veit, "Utilitarian Lessons from the COVID-19 Pandemic for Non-Pandemic Diseases", *The American Journal of Bioethics,* 21, no:12, (November 2021): 40-41.

[69] Archard, et al., "Is it wrong to prioritise younger patients", 1.

[70] Michael M. Rivlin, "Why the Fair Innings Argument is not Persuasive?", *BMC Medical Ethics*, (2000): 3-4.

[71] White and Lo, "A Framework for Rationing Ventilators, 1773; Piazza, "Saving Limited Resources", 20.

personal rights might cause unexpected losses to the society's wellbeing such as the resistance to wear masks or to get vaccinated.[72]

As noted by Emanuel, the value of maximizing the benefits is in line with both the utilitarian ethical approaches that concentrate on societal outcomes and the non-utilitarian ones focusing on the individual value of each human life. However, a cautious balance is to be kept between these two approaches.[73] Zeneli et al. also emphasize that the value of an individual's health and the collective health at the societal level have to be harmonized for reaching the core basic rights of equality, universalism and fairness.[74] Faggioni et al. focus on the difficulty of reaching this balance and favor the approach based on the principle of distributive justice. Yet they also underline the necessity that this principle has to be reinterpreted in line within a *"personalistic perspective"* to avoid any legitimization of discrimination against the elderly.[75] Montero-Odasso et al. share the same view and recommend that triage decisions for older patients should be individualized since older persons' neither capabilities nor functionalities are tightly attached to their ages.[76]

White and Lo suggest that if the patients who have a very low likelihood of survival are granted an indefinite use of scarce resources, then this is also likely to jeopardize the goal of maximizing the benefits at the societal level.[77] It might be true that it is mostly the elderly ones who have some comorbidities besides the Covid-19 disease; however it still might not be the case for every old age patient. Yet, the specific condition of each old patient has to be determined on an individual basis when delivering such significant decisions. This approach necessitates the recognition of older persons as a heterogeneous group like all other individuals rather than a homogeneous one all having the same physical or mental conditions. Older persons are all diverse in terms of their health and functioning, their education and income levels and such. They can still be fit and active. Yet, age is a weak indicator in terms of health conditions. Therefore,

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[72] Browning and Veit, "Utilitarian Lessons from the COVID-19", 41.

[73] Emanuel et al, "Fair Allocation", 2052.

[74] Zeneli et. al., "Identifying ethical values", 8.

[75] Maurizio P. Faggioni, et al., "National Health System Cuts and Triage Decisions During the COVID-19 Pandemic in Italy and Spain: Ethical Implications", *J Med Ethics*, no.47, (2021): 304.

[76] Manuel Montero-Odasso, et al. "Age Alone is not Adequate to Determine Health-care Resource Allocation During the COVID-19 Pandemic", *Canadian Geriatrics Journal,* 23, no.1, (March 2020): 153.

[77] White and Lo, "A Framework for Rationing Ventilators", 1774.

generalizations which perceive the elderly alike and ignore the diversity of them should be avoided.[78] Because as pointed out by Dewhurst, not all individuals age at the same rate and to the same extent.[79] Hence, triage decisions should not be based on chronological age alone.[80] They should be accompanied by other factors such as frailty scales and detailed geriatric assessments. This is also stressed by the European Geriatric Medicine Society.[81]

V. Application of the Solidarity during the Covid-19 Pandemic

The principle of solidarity enshrined under Article 2 of the Treaty on European Union (TEU) is regarded as one of the core values on which the society of the EU Member States is founded. Under Article 3/1 TEU, the EU has undertaken the duty to promote solidarity as an objective. The concept of solidarity is considered as a fundamental principle in terms of more specific Treaty provisions such as the ones concerning the Common Foreign and Security Policy (Article 21 TEU) as well as EU asylum policy (Article 80 TFEU).[82]

The Covid-19 pandemic tested both the EU institutions and the Member States in terms of the principle of solidarity when Italy sent a call for urgent support at the onset of the pandemic. In mid-March 2020, the Italian Government sent a call to activate the EU Civil Protection Mechanism covered under the solidarity principle which had a very slow yet if any response from other Member States.[83]

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78 Nancy Morrow-Howell and Ernest Gonzales, "Recovering from Coronavirus Disease 2019 (COVID-19): Resisting Ageism and Recommitting to a Productive Aging Perspective", *Public Policy & Aging Report*, XX, no. XX, (2020): 2; Sarah Harper, "The COVID-19 Pandemic and Older Adults: Institutionalised Ageism or Pragmatic Policy?", *Journal of Population Ageing* no. 13, (2020): 421.

79 Elaine Dewhurst, "Are Old Workers Past Their Sell-by-Date? A View from UK Age Discrimination Law", *The Modern Law Review*, 78, no.2, (2015): 215.

80 Leniza De Castro-Hamoy and Leonardo D. De Castro, "Age Matters but it should not be Used to Discriminate Against the Elderly in Allocating Scarce Resources in the Context of COVID-19", *Asian Bioethics Review*, 12, no.3, (2020): 334.

81 David-Martinez Selles, et al., "Ethical Issues in Decision-making Regarding the Elderly Affected by Coronavirus Disease 2019: An Expert Opinion", *European Cardiology Review*, 15, (2020): 2.

82 Anne Joppe, "EU Solidarity, Illustrated by the Covid-19 Crisis: What does EU Solidarity mean in the context of free movement of goods and persons and how is this illustrated by the response to the Covid-19 pandemic?", *Utrecht Law Review*, 17, no. 3, (2021): 132.

83 Bob Deen and Kimberley Kruijver, "Corona: EU's existential crisis, Why the lack of solidarity threatens not only the Union's health and economy, but also its security",

The EU once more failed to respond timely to this crisis and it took some time for the solidarity to be rebuilt among the members. During this period the public support for the European integration in Italy has dramatically decreased in response to the Union's hesitation for dealing with the crisis. Italian citizens seemed to have lost their trust in both the EU institutions as well as the other Member States when the immediate medical supply support arrived from countries such as China and Russia.[84] Accordingly, the European Commission triggered the European Civil Protection Mechanism to send some medical experts and equipment from other members to Italy.[85]

Following the weakness of the Union in the initial stage, the Franco-German initiative for financially supporting those members mostly hit by the pandemic, produced its fruits despite the long-lasting controversies in the European Council particularly led by the Dutch side. The negotiations on the details of the recovery fund proposal introduced by the Commission were long and tense since the Member States could not easily agree on the form of the financial support to be provided. Sweden, Denmark, Austria and Finland advocated by the Netherlands were quite concerned about the issue as to whether the funds would be provided more in the form of loans or grants. The northern European countries were not against the idea of any financial support, yet they were of the opinion that the funds would rather be provided as loans than grants while Italy argued for the opposite. The negotiations ended with a compromise through which the Member States agreed on a recovery plan to be worth more than 500 billion Euros. Italy was eventually provided with an unprecedented financial package amounting to almost 209 billion Euros[86] which meant that the EU showed its full solidarity to Italy despite the initial criticisms.

Clingendael, Netherlands Institute of International Relations, (April 2020): 2; Joppe, "EU Solidarity", 137.

84 Erik Jones, "Italy and Europe: from competence to Solidarity to competence", *Contemporary Italian Politics,* 13, no.2, (April 2021): 200- 202.

85 Jean Claude Cachia, "The Europeanization of the Covid-19 Pandemic Response and the EU's Solidarity with Italy", *Contemporary Italian Politics*, 13, no.1, (January 2021): 91.

86 Jones, "Italy and Europe", 202-204; Cachia, "The Europeanization of the Covid-19 Pandemic Response", 92-93.

VI. Some Suggestions on the Formulation of a Regulatory Framework for Triage at the Union Level

As mentioned earlier, the EU has been holding a shared competence with the Member States in terms of public health matters as formulated under Article 168 TFEU. Yet, the prior competence has been given to the Member States to act in this field in line with the principle of subsidiarity. The EU has earlier set up an agency -the European Centre for Disease Prevention and Control- with an aim to enhance the Union's capacity to respond to the needs of the Member States in times of such crises. Furthermore, it introduced a framework concerning crisis preparedness and responses to cross-border health threats under the EU Decision No. 1082/2013 on Serious Cross-border Threats to Health[87] in 2013 accompanied by the Early Warning and Response System as well as a Health Security Committee to coordinate these matters.[88]

Yet, it's clear that these mechanisms remained quite ineffective to cope with the pandemic. The Member States could not address the crisis related problems within a harmonious approach and continued to implement their national risk plans at the outset of the pandemic[89] which led to a more catastrophic outcome as revealed in the case of Italy. To compensate its late response, the EU introduced a new Regulation 2022/2371 on Serious Cross-border Threats to Health[90] in December 2022 which repeals the Decision No. 1082/2013. This instrument is supported by a Communication setting out the first elements of a European Health Union which can be regarded as positive initiatives and concrete steps for the Union.

Yet, one wonders whether or not these initiatives might be sufficient against any further cross-border health crises which might emerge in the future. The Union and its Member States are under the duty to protect particularly the disadvantageous groups against any differential treatment

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[87] Decision No 1082/2013/EU of the European Parliament and of the Council of 22 October 2013 on serious cross-border threats to health and repealing Decision No 2119/98/EC, OJ L 293, 5.11.2013. This decision is longer in force.

[88] Andrea Renda and Rosa Castro, "Towards Stronger EU Governance of Health Threats after the COVID-19 Pandemic", *European Journal of Risk Regulation*, 11, no.2, (2020): 276.

[89] Alberto Alemanno, "The European Response to COVID-19: From Regulatory Emulation to Regulatory Coordination?", *European Journal of Risk Regulation*, 11, no.2, (2020): 313.

[90] Regulation (EU) 2022/2371 of the European Parliament and of the Council of 23 November 2022 on serious cross-border threats to health and repealing Decision No 1082/2013/EU, OJ L 314, 6.12.2022.

during these extraordinary circumstances. It is to be reminded that the EU law protection for age discrimination is restricted to the field of labour market. That's why, it's very significant for the Union to immediately adopt the Commission's long-waiting 2008 Directive proposal which brings a protection mechanism against discrimination based on several grounds including age outside matters of employment or occupation.

In 2021, the German Federal Constitutional Court delivered a judgement concerning the alleged discrimination of disabled persons in terms of triage decisions made during the COVID-19 pandemic. The case was brought by persons with severe disabilities who argued that they were not adequately protected by the German legislator when shortages took place for the allocation of medical resources. The Court ruled that the legislator has breached its obligation to take the necessary measures to prevent any discrimination targeted against persons with disabilities in the allocation of scarce intensive care resources during the pandemic. The Court stated that the non-binding professional recommendations issued by the German Interdisciplinary Association for Intensive Care and Emergency Medicine were not fully capable of eliminating the risks of disabled persons to be disadvantaged in those decisions. According to the Court, *"respect for human dignity prohibits any weighing of life against life."* The Court ruled that the German legislator could define constitutionally sound criteria for decisions on how to allocate scarce medical resources during such extraordinary times.[91] Yet, it might be logical to set the Court's ruling as a precedent for adopting a protective approach for old age persons as well since they form another disadvantageous group likewise disabled persons in terms of being treated within a similar discriminatory manner.

Several actors were involved in the making of the triage decisions in the Member States during the pandemic. However, in line with the German Constitutional Court's ruling, Domenici and Engeser, suggest in their recent study that the intervention of a central legislative body is of particular significance in many aspects. According to them, it would produce better outcomes when the legislature draws the normative framework for triage decisions and then leaves a large room to health professionals for deciding in

[91] "The legislator must take effective measures ensuring that persons with disabilities are protected in triage situations caused by the pandemic", *Bundesverfassungsgericht,* Press Release No.109/2021 of December 2021, order of 16 December 2021, 1 BvR 1541/20, pp.1-3.

specific cases. Moreover, it could eliminate the risk of differential treatment at hospitals located in different parts or regions of the countries.[92]

The COVID-19 pandemic process obviously revealed that not all the Member States of the EU were fully capable of coping with the crises alone themselves. Though the public health field lays within the hands of the Member States, one shall note that the EU would still be under the duty to intervene if the objective of an action is not sufficiently achieved at the Member State level as required by the principle of subsidiarity (Article 5 TEU) under EU law. This is worded under Paragraph 53 of the Regulation 2021/522[93] as: *"Given the nature and potential scale of cross-border threats to health, the objectives of protecting people in the Union from such treats and increasing health crisis prevention and preparedness cannot be sufficiently achieved by the Member States alone. In accordance with the principle of subsidiarity…, action at Union level can also be taken to support Member States' efforts in the pursuit of a high level of protection of public health, ...and to address inequalities and inequities in access to healthcare throughout the Union…while respecting the Member States' competence and responsibility in the areas covered by the Programme."* Yet, the Union is precisely granted the competence to act when the Member States cannot address inequalities in terms of access to healthcare on their own. Given that the basic fundamental rights of the right to life and the right to health are strongly protected under EU law, then it could bring more efficient outcomes if the EU legislator could draw a set of guidelines which would recommend some fair allocation principles for triage decisions in the event of scarcity. Hence, the COVID-19 pandemic proved that the competences of the EU should be increased in the health field and more solid steps have to be taken by the Member States towards the foundation of an EU Health Union. This is not likely to jeopardize the Member States' competences in the health field if it is used by the Union in line with the principle of proportionality.

Yet if the Union is to be given a role in defining a regulatory framework for triage decisions, then this could be done through invoking the Open Method of Coordination which is a soft law instrument mainly applied in the

[92] Irene Domenici and Franciska Engeser, The Institutional Tragedy of Pandemic Triage Regulation in Italy and Germany, *European Journal of Health Law,* 29, no.1, (2022): 105 and 129.

[93] Regulation (EU) 2021/522 of the European Parliament and of the Council of 24 March 2021 establishing a Programme for the Union's action in the field of health ('EU4Health Programme') for the period 2021-2027, and repealing Regulation (EU) No 282/2014, OJ L 107, 26.3.2021.

social policy field. Under this context, it might be possible to rely on Article 168/2 TFEU which already lays down the legal basis for the application of this non-legislative mechanism. Hence, the Commission -in close contact with the Member States- is granted the competence *"…to take any useful initiative to promote such coordination, in particular initiatives aiming at the establishment of guidelines and indicators, the organization of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation…"* Yet, the Member States might set up their own national allocation criteria to be invoked in triage decisions taking into consideration the guidelines prepared by the European Commission. The Member States might exchange their best practices that might eventually lead to a higher level of protection for all the disadvantageous groups particularly the older persons living in an increasingly ageing Union.

Conclusion

The COVID-19 pandemic revealed all the deficiencies in the existing health care systems of several EU Member States as well as the structural capacity of the EU. Disadvantageous groups particularly the older persons who were already experiencing numerous differential treatments in their daily lives, once more were subject to practices leading to discrimination during the pandemic. Persons over certain ages were denied from having access to medical treatment and were sacrificed for others in some European countries. Yet, the right to life and the right to health are the fundamental rights of humans to be protected and guaranteed by their countries.

It's clear that determining on a set of fair allocation criteria or principles which would be implemented in terms of scarcity situations of medical resources is a highly challenging and hotly debated task. Yet, a solid balance has to be kept between utilitarian and egalitarian ethical approaches when drafting these guidelines. Patients should not be largely categorized relying merely on their particular characteristics and automatically excluded from having any access to basic fundamental rights which otherwise might amount to direct discrimination. Hence, old age persons shall be treated likewise any other groups of persons in the society, on the basis of their diverse and personal conditions.

It's seen that the competence of the EU in terms of health field is rather limited and complementary since it firmly remains at the hands of the Member States. Yet, the pandemic also clearly revealed that some EU

countries could not cope sufficiently well with the process alone themselves. When that is the case, then one might consider the possibility of testing the external limits of the EU's competence in health field since the principle of subsidiarity besides limiting the competence of the Union, indeed gives the competence to the Union if the objective of an action is not to be achieved as efficient as the Union when it is implemented by the Member States. The EU already needs to intervene in the process through the principle of solidarity in terms of reducing the negative outcomes of these disasters. Then, why the same Union should not be given any role in the very beginning in terms of defining and recommending some common ethical criteria at the minimum level for the allocation of those scarce resources which could be non-binding yet guiding in its very nature? This might lead to the conduct of more effective national response plans and policies accompanied by having more organized structural capacities which would treat every individual on an equal basis on behalf of the Member States. It would also reduce these dreadful consequences which had been experienced during the Covid-19 pandemic in the middle of 21st century Europe.

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