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Vaccines aren't a reward

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Should past mistakes play a role in how medical assistance is prioritised? If so, the debate on the prioritisation of health resources will take on a whole new dimension.

If Oslo receives more vaccine doses because of its infection rate, this would be a kind of 'reverse reward' (1). It was the mayor of the town of Molde, Torgeir Dahl, who expressed this view in a discussion on the skewed distribution of COVID-19 vaccines based on where infection rates are highest. The reason was that he was not impressed by what Oslo, the capital of Norway, had achieved. According to Dahl, the infection rate shows that Oslo's performance is far from good enough.

Thus his argument is two-sided. Firstly, he claims that the capital city's management of the pandemic is not up to the required standard. Secondly, he says that *on account of* this poor management, if Oslo receives a comparatively greater number of vaccine doses, it would be a 'reverse reward'.

What does 'reverse reward' mean?

It means that Oslo perhaps should not receive a greater number of vaccine doses (geographic prioritisation) on account of the poor performance of political leadership and/or the population. In other words, importance is attributed to past choices and potential mistakes when geographic prioritisation is assessed. Up to now, we have endeavoured to protect those most in need of protection, prevent the health service from being overwhelmed, and get society back on its feet again as soon as possible (2, p. 14). This emphasis on responsibility is a new dimension which appears not to be introduced for reasons of usefulness, but rather as a form of fairness: Oslo does not deserve more vaccine doses because of the way they have managed the pandemic.

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A trend of the times

The stronger focus on (personal) responsibility in health matters appears to be caused by at least two factors (3). On the one hand, the spread of lifestyle diseases means that individual behaviour is subject to closer scrutiny. On the other hand, the responsibility dimension has

become increasingly prominent in political thinking. Providing help to those who are in difficult circumstances and who cannot be held responsible for their own predicament is uncontroversial. The question is whether those who can more or less thank themselves for their afflictions are entitled to society's assistance, or at the very least, whether their right to such help should be restricted. The issue of whether personal responsibility should count in the prioritisation of medical assistance has triggered academic debate (4) and has been discussed by government-appointed committees (5).

What should our answer be?

If you answer that Oslo has not done a poor job, or that they cannot be held responsible for the infection rate, you are responding to the allegation about the capital's management of the pandemic. You are not *actively* taking a stance on the premise that responsibility is in any way relevant in the distribution of vaccines. We all feel a need to reply to allegations. But if we fail to address the presumption that personal responsibility should count in the prioritisation of medical assistance, this may well turn it into an immutable truth.

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