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# NECROPOLITICS AND SCARCE RESOURCE ALLOCATION: LETTING DIE IN DEATH-WORLDS WITHIN THE FRAMEWORK OF LIFEBOAT ETHICS

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ABSTRACT. The debate about the allocation of scarce healthcare resources was one of the most heated during the COVID-19 pandemic. The main ethical concern is what should we do in crisis periods when there are unmet demands for specific health goods, products, and services. One of the assumptions for the authors in this field is to take scarcity as a given neutral fact. Following this, literature mostly focuses on preference scales and optimal allocation measures, obliterating substantive discussions on how scarcity is produced and differentially distributed. Such an obliteration is what took Tom Koch (2013) to criticize "lifeboat ethics" – for him, we should not be focusing on how to distribute places in the lifeboat, but rather on why we ever allowed ourselves to navigate in such circumstances. His argument can be used to defend a duty to plan, which, if fulfilled, would prevent tragic choices. Here, I follow a different argument, related to how scarcity plays a role in the maintenance of status quo in necropolitical frameworks. In those settings, scarcity is not an accident of crisis periods, but a permanent structural factor and a means of governing. While we keep our ethical lens away from how scarcity is produced in these countries, we run the risk of leaving aside antecedent public choices that prioritize certain interests over the life of the ultimately killable ones – i.e., the decisions that reify and naturalize scarcity.
KEYWORDS: necropolitics, public choices, scare resources, lifeboat ethics, COVID-19, triage, health policy.

## NEKROPOLITIKA IR RIBOTŲ IŠTEKLIŲ PASKIRSTYMAS: LEIDIMAS MIRTI MIRTIES PASAULYJE REMIANTIS „GELBĖJIMOSI VALTIES" ETIKA

SANTRAUKA. Debatai apie tai, kaip turi būti paskirstyti riboti medicininių priemonių ištekliai, tapo ypač audringi COVID-19 pandemijos metu. Pagrindinis etinis rūpestis – kaip turime elgtis krizės situacijoje, kai padidėja medicinos priemonių, produktų ir paslaugų poreikis.

Viena iš šioje srityje dirbančių autorių prielaidų yra įsitikinimas, jog trūkumas yra natūrali duotybė. Remiantis šia prielaida, paprastai orientuojamasi į pirmumo klausimą ir optimalų paskirstymą, užmirštant esminį klausimą apie tai, kaip trūkumas yra sukuriamas ir netolygiai patiriamas. Toks užmaršumas paskatino Tomą Kochą (2013) kritikuoti „gelbėjimosi valties" etiką. Jo manymu, turime kreipti dėmesį ne į tai, kaip paskirstyti vietas gelbėjimosi valtyje, bet į tai, kodėl atsidūrėme tokioje situacijoje. Jo argumentai veda link prievolės planuoti, kurią įgyvendinus nereikėtų daryti tragiškų pasirinkimų. Savo straipsnyje aš remiuosi kitu argumentu, teigdama, kad trūkumas padeda išlaikyti *status quo* nekropolitikos situacijoje. Žvelgiant iš šios perspektyvos, trūkumas yra ne atsitiktinumas, ištinkantis kritiniu laikotarpiu, o nuolatinis struktūrinis veiksnys ir valdymo priemonė. Jei etinis požiūris neatsižvelgia į tai, kaip trūkumas yra produkuojamas šiose šalyse, tada rizikuojama pražiūrėti ankstesnius viešus pasirinkimus, kurie suteikia pirmumą tam tikriems interesams ir nepaiso gyvybių tų, kuriems leidžiama mirti, – būtent šie sprendimai sudaiktina ir natūralizuoja trūkumą.
RAKTAŽODŽIAI: nekropolitika, vieši pasirinkimai, išteklių trūkumas, „gelbėjimosi valties" etika, COVID-19, rūšiavimas, sveikatos politika.

> *We cannot know why the world suffers. But we can know how the world decides that suffering shall come to some persons and not to others. While the world permits sufferers to be chosen, something beyond their agony is earned, something even beyond the satisfaction of the world's needs and desires. For it is in the choosing that enduring societies preserve or destroy those values that suffering and necessity expose. In this way societies are defined, for it is by the values that are foregone no less than by those that are preserved at tremendous cost that we know a society's character* (Calabresi, Bobbitt 1978: 17).

> *The land is covered with ditches/and at any carelessness of life/ death is certain./ The bullet doesn't miss its target, in the dark/ a black body wobbles and dances./ The death certificate, the ancients know,/ has been drawn up since the slavers* (Evaristo 2017: 17).

## Introduction

One of the most important debates we have engaged in during the pandemic concerns the distribution of medical goods and the allocation of scarce health care resources. The main ethical preoccupation in these debates revolves around what should be done when structuring triage policies that allocate certain goods to specific individuals. This kind of policy is especially relevant in periods of crisis in which there are unmet demands for highly specific goods, products, and health services. The ethical literature dedicated to providing moral reasoning to these policies can be referred to as the "ethics of scarce resources allocation". A common assumption maintained by the authors who work in this field is that scarcity is a natural fact, a given constraint of reality. For scarcity to occur, it is enough that there is a demand for essential medical resources greater than the supply. Thus, ethics scholars have long obliterated the evaluation of *what causes* scarcity and *whom it*

*afflicts*, rather focusing on the principles that should guide the allocation *when there is scarcity of resources*.

By taking scarcity as a fact, the – more frequently, utilitarian – literature, which points out preference scales and optimal allocation measures, seems to obliterate deeper discussions about justice and equality. In this article, I formulate a counterintuitive argument: instead of promoting fairness, the logic of scarce resource allocation policies ends up maintaining and reinforcing necropolitical settings. I intend to take a step back and look at the conditions that configure scarcity to some people, and, at the same time, reinforce abundance to others. I therefore pose the following question: "Scarce for whom?". From this, one other question arises: "How and why does a good or a service become scarce?" To answer them, I will investigate the logic underlying the ethical analysis that takes scarcity as a natural fact. The goal is to identify the necropolitical viewpoint through which the theoretical recommendation not to allocate resources to "killable" populations becomes not only correct, but also a tool of death politics. Doing so means reassessing the scarcity problem through a different lens, hence asking "what place is given to life, death and the human body [...] [and] how are they inscribed in the order of power?" (Mbembe 2003: 12).

## 1. Which comes first: scarcity or precarity?

The idea of scarcity has been foundational to political thinking. Its most generic meaning is that of a shortage of means to achieve desirable ends of action. In the ethical literature, scarcity became a paramount factor to decide the rights and wrongs when it comes to the destination of goods. It is in the intersection between clinical ethics – when it comes to decision-making concerning micro-allocation – and public health ethics – when we consider macro-allocations in a systematic context – that scarcity became an inevitable topic, i.e., *once scarcity is not avoidable*, how should we destinate goods and services that can have impact on important matters, such as the likeability of living and dying, for the potential beneficiaries.

The issue of healthcare resource scarcity is hence not new in bioethics and medical ethics[1]. On the one hand, the rationing of essential resources that exist in

[1] See, in this sense, the works by Norman Daniels in the 1980s, when the author started intersecting Rawlsian justice theory and the issues of fairness in the allocation of scarce resources. The fundamental question of the literature that followed this tradition is articulated by this author: "If we can assume some scarcity of health care resources, and if we cannot (or should not) rely just on market mechanisms to allocate these resources, then we need such a theory to guide macro-allocation decisions about priorities among health care needs" (Daniels 1981: 146).

smaller quantities than what is demanded raises the question of how the medical needs of some vulnerable people will be aggregated in relation to those without the said vulnerabilities (Bickenbach 2016). On the other hand, during health crises caused by such situations as war, epidemic, pandemic, or natural disasters, the ethical structuring of rationing strategies is centered around an immediate response – often dissociated from approaching conjunctural political themes that trigger the events that lead to scarcity.

In the context of an event of epidemic or pandemic, the increasing overload of outpatient clinics, emergency departments, hospitals and intensive care units is on the agenda, which leads to a critical shortage of personnel, space, and supplies with serious implications for the treatment of the patients (Hick, Biddinger 2020). Thus, in this scenario, many resources can be classified as available in a lower quantity in relation to what is demanded, such as personal protective equipment, antiviral drugs, hospital beds, mechanical ventilation, and vaccination among others (Verweij 2009). For the above-mentioned ethical literature of scarce resources allocation, the most fundamental question that pandemic planning needs to answer is "who gets what, if not everyone can get what is needed". It is in this context that prioritization lists, triage protocols, and rationing policies for certain goods come into play. That is to say: in view of the scarcity of essential resources, should priority be given to patients who have better chances of survival or to more vulnerable patients, who will certainly die if they do not have the resource assured? Should we prioritize adults or children? Should health professionals engaged in fighting the pandemic be prioritized over other citizens? These are hence the questions that address the sheer reality of scarcity. The narratives that follow from them are usually anecdotal examples of one individual demand against another – thus, when the story starts, scarcity is already there. However, what I try to do in this section is suggest we should start the story from a different point, trying to see what is "written in white ink" before the first chapter of the tale of tragic choices that motivate triage protocols.

### 1.1. Two naturalizing narratives of scarcity

According to Steve Rayner (2010), there are two narratives about scarcity in modern human development discourse – both naturalizing narratives present different, but equally tantalizing justifications for perpetuating structural discrimination. One of them perceives scarcity as a reason to institutionalize the idea of "limits to growth", which is entangled with the notion that the world is finite, so we should be careful about depleting the natural goods available to us. Inconsequential growth of the population leads to a rapid consumption of the resources on which humanity's

survival depends. This is an explicitly neo-Malthusian narrative – that is, if there are too many people making demands on finite resources, this narrative necessitates the solution of reducing the level of demand or the number of demanders. Given that reducing the level of demand means the curtailment of individual inalienable rights, the alternative is to limit the legitimate demanding population by creating different classes of subjects, some of which will be able to demand the fulfilment of their requests (e.g. citizens), while others will not (e.g. foreigners). Regarding pandemics and epidemics, implicitly neo-Malthusian narratives frame the Covid-19 event as a *necessary* positive check, by claiming that "humanity is the virus" that must be controlled so a situation of natural resource depletion does not lead to unredeemable scarcity.

The second possible narrative assigns scarcity a more technical role in the definition of procedures, grounding the so-called "science of resource allocation". This second narrative is traditionally underpinned by the utilitarian principle of achieving the greatest satisfaction for the greatest number of persons[2]. Underlying this narrative is the command to provide the greatest amount of social good at the highest level of aggregation, which does not ensure proportional or equal satisfaction for the various communities or individuals who make up unequal societies. This kind of general commitment traces back to the "innumerate ethics" of Derek Parfit, who commands saving the larger number, because – "Each counts for one. That is why more count for more" (Parfit 1978: 301). Different indexes can be used to compare potential beneficiaries of the resource considered scarce, such as likeability of survival, life expectancy in years, social worth of the receiver or quality of life expected. Hence, in a situation of limited seats in a lifeboat, the allocation of seats viewed from the utilitarian perspective would have to gravitate towards those who were expected to survive the extreme circumstance of the boat being adrift for a long time, or to live more after the rescue is conducted, or to generate more profit for society, or to both live more and have better quality of life.

Both narratives presented fail to problematize descriptive readings of scarcity. In that sense, in these readings, the factors from which scarcity originates, even when identifiable, do not immediately need attention. Scarcity moves to the background of the premise that not everyone will receive what is necessary to survive – the question is thus "under given constraints", what should be done?

[2] We could say that there are three main ethical frameworks for manufacturing triage protocols, which are egalitarian and utilitarian, originating respectively from Norman Daniels and Derek Parfit, and prioritarian frameworks. The most dominant framework in scenarios of scarcity tend to be utilitarian. To read about the differences between these frameworks, see Tolchin, Hull, Kraschel 2020; Vinay, Baumann, Biller-Andorno 2021.

Such framings never address the issues of structural inequality prior to the need of allocation protocols in the face of scarcity – although the development of protocols itself discursively uses the lexicon of equality and fairness[3]. Contesting such naturalizing and descriptive readings of scarcity, I want to subvert the question by Emanuel et al. (Emanuel et al. 2020), whose aim is to understand how scarce resources can be fairly allocated during a pandemic, in order to ask: is it even possible to fairly allocate scarce resources from a utilitarian point of view during a pandemic, given that 1) the scarcity of certain goods in such a pandemic can be predictable; 2) the world is made by historically unequal societies; 3) the scarcity of certain goods is artificial at best.

### 1.2. Some count for more than others: precarious lives have always lived in scarcity

One of the many tales Covid-19 pandemic brought about is the framing of the event as caused by a "democratic virus" that would affect us all regardless of our class, gender, and nationality – for that reason, collective action and union was called upon around the globe. Such plot obliterates the historically embodied nature of the virus in a context of growing globalization, and its spread in a world marked by differentially distributed vulnerabilities. Even though dependence and precariousness pervade human life in all of its aspects, it is the unequal distribution of precarity that renders some lives as not "potentially grievable". These are lives that carry the burden of "starvation, underemployment, legal disenfranchisement, and differential exposure to violence and death" (Butler 2009: 25). There was hence no equal or democratic exposure to the virus, nor was there equal access to the means necessary to fight it. The metrics of grievability, while represented by impartial numbers, hide the fact that we do not mourn for the same subjects.

The pandemic, according to Ana Maria Costa and others, is the phenomenon that exposes the "abysmal social inequality now as scandalously exposed as it was previously denied" (Costa et al. 2020). In this scenario, the main sources of scarcity have been pointed out, specifically, as the availability of masks, specialized beds in ICUs, and respirators (Emanuel et al. 2020; Ranney et al. 2020). Although it is not trivial to identify the pandemic's scenario as exceptional – given that specific measures are put in place to safeguard population better – we should acknowledge that, to certain groups, none of these resources could previously be considered as

[3] In this sense, we observe the performative assertion in the allocation ethics literature that the suggestions provided are "egalitarian" or based on equality. This type of statement is generally made without further reference to which conception of "equality" is being employed, and why the specifically considered reflection would be consistent with it. Even though I do not have space to develop this idea here, I understand these statements as self-legitimizing devices.

widely available – in fact, such services and goods have always been inaccessible to a certain part of the population. For this group, scarcity does not stem from pandemics – it has always been there in multiples areas of their lives. For this group, the Covid-19 pandemic is hence not an extraordinary event, but rather a continuation of a process of slow death that started long ago. In that sense, after decades of a poor infrastructure for accessible medical care in many countries, whether through the limitation of public funding for entities that provide health goods and services, or through the neglect of the duty to plan, the national governments cannot guarantee or even manage life "except through the crudest forms of non-medical control and visceral violence" (Lee 2020).

For this reason, it is necessary to take a step back and consider the possibility of these rationing protocols being not a measure for fairness, but rather a continuation of a death politics, that justifies letting the disposable die. We must not thus see triage protocols that perpetuate discrimination as a sign of responsive and efficient governments that save many because each person matters equally.

What I propose is that these protocols are also a technology of necropolitics. Under the mask of optimization and impartiality, they end up justifying the disposal of the *disposable* as an outcome of diligent administration.

## 2. Lifeboat ethics as a dispositive of enmity tales

Important metaphors have been used during the pandemic to reinforce the idea of moral equality of subjects; the expressions such "we are all in the same boat", "the virus is democratic", and "the pandemic does not see colour, race, gender [...]" have become jargon for those who insist on the methodological neutrality of the demand assessment. However, these metaphors obliterate the unequal structuring of "social boats" and the political precariousness of vulnerable subjects in the face of the deadly virus. In that sense, "a rising tide, alas, does not lift all boats and certainly does not address the issues of those that may be holed, ill equipped or poorly provisioned for the voyage" (Rayner 2010: xviii). Concealed underneath the metaphor of a "democratic virus" is thus a command to performative impartiality.

Since the virus is democratic[4], it becomes less important to understand the profile of those who are granted resources, due to the commandments of optimization and maximization of survival or benefit. It is not relevant to pose

[4] A rebuttal of the idea of a democratic virus in the context of pandemics has been made by De Lange in relation to HIV/AIDS virus: "The virus is not democratic, for it affects the poor; it is sexist, because it hits especially women; it is racial, because it touches the black community far more than the white; it is curable, in the sense that there are anti-retroviral drugs available, but only outside happy few rich who have financial access to them" (De Lange 2006: 10).

questions such as: are there patterns of race, class, gender, and disability identifiable in the mass of people who do not qualify as preferential beneficiaries according to these parameters? The obliteration of this question happens because each and every one is treated as a unity, and regardless of their traits, survivability of the biggest number of units matters more than the profiles of the units saved. This kind of metaphor[5] is precisely what underlies lifeboat ethics, which is the standard structure of protocols of scarce resource allocations in bioethics.

According to Tom Koch (Koch 2002, 2012), the first case of lifeboat ethics in the face of scarcity was that of the William Brown ship. In 1841, the sailing ship William Brown, which was carrying 65 Irish and Scottish emigrants searching for a new life in the United States, hit an iceberg and sank. Half of the passengers and all the crew onboard were saved by two small lifeboats. The next night, the passengers of one lifeboat started to worry that their vessel was in danger of being submerged. For that reason, 16 of the passengers in that boat were thrown overboard. This terrifying tale became the first historical example of "lifeboat ethics", which has turned into a general schematic response to problems of scarcity in bioethics. It portrays scarcity either as a natural fact of reality – i.e., number of seats in a boat which is lower than the number of prospective occupiers, or as a given, as scarcity is seen as independent of antecedent decisions made within a complex system of social organization.

It is not argued, e.g., that prior decisions exacerbate or even produce scarcity that seems to dictate further choices, which, in their turn, are perceived as a problem of limited supply of particular goods. It seems as if the moment in which the lifeboat comes into play and the decision-making moment in which the question who gets thrown overboard is posed is the beginning of the story. However, in most cases, it is the continuation of a chain of decisions based upon the prioritization of certain interests. For example, the story about the William Brown does not mention that this boat was one of the hundreds of ships that served in the Celtic migration in the 19th century. This massive migratory movement happened due to an encouragement by the British and European governments for whom migration would solve the problem of poverty caused by the changes in land tenure and industrial policies. Even more so, it is not told that other constraints made the situation more likely to happen, such as the pressures for the boat to

[5] Besides showing that the virus is not democratic and that we are not in the same boat, it is important to understand the performative use of such expressions in a way that covers up structural inequalities while also justifying its disregard. Giving equal weight to each one because of the supposed democratic aspect of the virus – without adjusting to consider positionalities pervaded by class, nationality, gender, and race – is a way to prioritize certain subjects who are already privileged with the rhetoric of seeming moral equality. In this way, not only does the lexicon of moral equality dismantle structural inequality, but also legitimizes it and reinforces its intangibility.

travel fast – as the faster the voyage, the more quickly a ship would earn its fees, turn around, and reload for profits – thus the chosen route was the fastest yet the most dangerous, which also meant the lack of preparation, as this was a boat travelling through dangerous waters without the assets required to accommodate all passengers in case of a ship wreck. As stated by Koch, "emigrants were an easily replaceable commodity" (Koch 2002: 12), and precaution might have seemed superfluous.

From this perspective, the event was caused by a confluence of social and economic factors, that led to the ship's sailing without auxiliary craft at maximum speed into an area almost certain to have icebergs. To read about this case and to realize these deaths occurred because these emigrants were considered as the disposable lives are in necropolitics was what made me establish a connection between critical bioethics and necropolitics in the first place. Whereas at the beginning of the Covid-19 pandemic I was concerned with the problem of disability discrimination in such triage protocols (Araújo et al. 2020), now I think that the very purpose of thinking within the framework of scarce resource allocation is to perpetuate discrimination under the veil of maximization of interest in conditions of scarcity. Here, I want to tackle how lifeboat ethics has become such a successful tale of animosity between virtually equal demanders of a seat in the boat – i.e., subject of rights to health.

### 2.1. The sacrificial willingness of legitimatizing triage: who navigates waters for what

When the migrants thrown overboard in the William Brown ship disaster had gone on the trip that would later condemn them to death, it could be argued that they had already been living *half-lives*. We need to remember that "no one leaves home unless home is the mouth of the shark", as stated by British-Somali poet Warsan Shire (Shire 2014: 23). Since the pre-emptive conditions of the disaster never came to light, the beginning of the story obliterates the accountability of the ones in charge of preventing the event. Letting some die so others can survive becomes a matter of fairness when lifeboat ethics is invoked, because the question ceases being substantive (why these people are on the ship) and becomes procedural (how to decide who gets a seat in the lifeboat given that places are scarce). That some must die for the common good becomes a given, as if there was, in the name of fairness, a sacrificial willingness in being thrown overboard – or not receiving a ventilator in the context of Covid-19. However, shedding some light on pre-emptive conditions is necessary to accurately understand how letting die became

legitimate. That is, long before the overloaded lifeboat was set adrift, bad choices had been made.

In health policy, lifeboat ethics has substantially influenced thinking about resource allocation, especially in low-income countries, in which it might look like it is naturally impossible to allocate locally available health resources *adequately* for all the people who need them to attain an acceptable level of healthcare. This means that in some localities, it is accepted that lifeboat ethics is the sole and only way to allocate resources correctly. In other places, lifeboat ethics also pervades bioethical thinking in the case of scarcities, which are the result of market choices – such as the availability of a drug or a treatment. However, even though lifeboat ethics became the paramount framework to highlight problems in scarce healthcare resource allocation, situations of scarcity in public health are not always the result of natural limitations – such as is the case of human organs for transplantation.

As stated by Guido Calabresi and Philip Bobbitt, scarcity is more commonly not "the result of any absolute lack of a resource but rather of the decision by society that it is not prepared to forgo other goods and benefits in a number sufficient to remove the scarcity" (Calabresi, Bobbitt 1978: 22). Calabresi and Bobbitt's evaluation is relevant to start an "interrogation of scarcity" (Schrecker 2012) because it encourages us to consider the stream of societal decisions, which in a society's history enable the consideration of the resource as scarce. Consider the case of famine: it may make "a great difference whether scarcity arose from a natural pestilence or drought and whether that pestilence or drought itself could be perceived as resulting from prior societal decisions, or whether scarcity is traced to deliberate or casual decisions to channel labor toward nonagricultural activities" (Calabresi, Bobbitt 1978: 151).

Following Calabresi and Bobbit, Matteo Cati (Cati 2022) provides an example of using the distinction between the first- (how much to produce) and second- (to whom allocate what is produced) order decisions in tragic choices to address the matter of vaccine scarcity. However, I believe such an application must be complexified in two ways. First, the wide spread of the virus that would cause the pandemic was predictable (see Davis 2006), hence it was possible to make decisions that would prevent scarcity of essential medical goods – such as ventilators – long before the event. The decision for not doing so shows a lack of preparedness that should be addressed. Secondly, the social determinants of health, related to nationality, class, race, gender, and disability-status, condition the second-order determinations, which depend on a chain of events that long precede the pandemic outbreak. Even though such a distinction might be pedagogically smart, both decisions are entangled with "market fundamentalism that is the value system

underlying contemporary globalization" (Schrecker 2012: 401). In this sense, asking "how much x to produce", x being a medical good that will be necessary for the survivability of all in the near future, is an action determined by the fact that many lives are expandable – thus, *killable*. Letting them die without x is not perceived as a "repugnant choice". The questions of "how much" and "who receives" have thus to be contextualized in a necropolitical framework.

### 2.2. Enmity tales and tragic choices: the winner always takes it all

The logics of the ethics of scarce resource allocation also dilutes macro-structural questions and makes them micro-individual ones, as it usually formulates the problems following this format: "A and B require a certain resource, but there is only one unit available. Considering A and B's relevant traits according to a chosen maximizing parameter, who should receive the resource?" This kind of formulation, however, creates a fictional animosity between two subjects of rights, who are virtually equal – all other things considered – but must be differentiated due to the scarcity of provisions. This assumption of equality – in the contexts of structural inequality – ignores that the abundance of essential resources does not guarantee the allocation of vital goods to most people even in situations of "normality".

The idea of the correlation between individual rights and moral equality is associated with the basic logic of universal access, according to which improving the living conditions of the population increases the level of healthcare, which, in its turn, can prevent, stop or mitigate health crises. However, universal access can be critically analysed as it does not amount to universal treatment, or equal care in all sectors of a health system. Some groups continue to face inequality and injustice even in supposedly universal health systems, before and during a crisis event (Robertson, Travaglia 2020). In this sense, there is no real antinomy between being a subject of a right to universal healthcare on an equal basis with others and suffering from precarity. This is especially true when we consider a particularly rudimentary form of utilitarianism, which is based on the idea that everyone has potential and equal access, even when, factually, not everyone will be provided with the necessary resources. In this way, the myth of universal access is not compromised by a material lack of service, and the narrative of moral equality amongst demanders of a good can be told without sacrificing impartiality.

## 3. Necropolitics: inserting killability in scarsity

> *The pandemic, if severe, will lead to an unusually high number of sick people over a large geographic area, all requiring care at the same time. As a result, human and material health care resources (available in normal times) will quickly be overwhelmed. Many of the sick will no doubt recover with minimal assistance, but others will become seriously ill and will need prolonged hospitalization, diagnostic facilities, various medications, and well-trained staff if they are to have a chance of survival* (Kotalik 2005: 424).

Although it appears that this excerpt was written in 2020, its publication date was in 2005, when it was already possible to predict the occurrence of a pandemic caused by the spread of an *influenza-type virus* that would affect the respiratory system of people worldwide. The first problem with pandemic preparedness plans, according to Jaro Kotalik, the author of the passage, consists in the allusion to the scarcity of resources, with an explicit or implicit presumption that scarcity is inevitable, and that planning for total availability of needed resources would be impossible. From this excerpt, it is also important to highlight the statement that in normal times the human resources and care materials that are absent during the pandemic would be available. Our question to this is: available to whom?

If it were possible to predict the occurrence of pandemics, it would always be possible to assume the latency of certain shortages. If we consider the pre-pandemic scenario, the claim that scarcity can be avoided is conditioned, however, by a decision on the financing of a certain resource to be stored, which can only be properly made when the costs to do so are estimated and considered. In this sense, the question arises: wasn't the moment of planning the right time to guarantee the availability of certain medical goods – such as ventilators – to truly "save the larger number", because "each counts for one"? Due to necropolitics, the answer to this question is negative because not every person "counts for one".

I argue that the absence of planning to prevent shortages during a pandemic in some people's lives should not be considered as an accident – the pandemic is also not an abnormal period of capitalism when it comes to individually experienced scarcity of essential resources. As stated by De Jesus (2020), there are expendable lives, considered to be killable – more than that, there are lives that are not even lives, due to the radicalization of their precarious conditions. Since even before the pandemic these subjects did not enjoy lives that are proper "lives", they are not equally considered as holders of legitimate claims or as demanders that deserve supply. To them, scarcity is not a side effect of the pandemic – however, scarcity is deemed to be intrinsic to the pandemic only because it also impacts "livable" lives. If subjects of disposable lives die, scarcity is irrelevant; relevance only arises

when the lack of resources affects non-precarious people. It is then that "ethics of scarce resources allocation" comes into play to secure that the rhetoric of efficiency and maximization of interest maintains its *status quo*, so the winner continues to take it all.

### 3.1. Necropolitics: letting the killable die

Even though the ethics of resource allocation lays the foundation for virtual moral equality between demanders, the parameters established to secure maximization are, in general, blind to structural matters. They do not account, for example, for a higher incidence of respiratory diseases in racialized populations (among the causal factors, we can think of residence in the peripheries, where big factories are located). Because the named parameters enter the scene when conditions of inequality are settled, they are of little use given the fact that poor people present higher incidence of coronary heart disease and obesity, due to the transformation of the global peripheries into junk food markets. Therefore, supposedly impartial triage protocols end up favouring the richer and "whiter" ones. I want to suggest, however, that instead of being a result of interest maximization, such triage protocols are the way they are because of the instrumental value they have for legitimizing necropolitics.

According to Mbembe (2003), necropolitics is something beyond the Foucauldian the "old sovereign's right to kill" that also manifests itself in the prerogative to expose other people – including citizens of a state – to the politics of death (including slavery and the state of war). A necropolitical system of governance is, therefore, the one that expresses its sovereignty through its ability to "make die" and "let die", via the systems of designation that consider certain populations as worthy of life and others as those that are not – and can therefore be exposed to harm. We could claim that necropolitics goes one step further than biopolitics, especially for former colonies. It posits that systems of power not only fail to protect the life of those deemed unworthy, but actively sanction their death and primarily achieve this by exposing certain populations to conditions so detrimental to life that they ultimately perish. We might say that while biopolitics draws its vitality from a control of life, necropolitics is the very instrument by which neoliberalism converts death into vitality, deadness into profit. Crucially, necropolitical conceptualizations assume that there are certain "technologies" that fuel processes of violence and distribute it along certain lines. For Mbembe, these are primarily racism, in line with Foucauldian thinking, and neoliberalism, or more specifically the "subordination of everything to impersonal logics and to the reign

of calculability" (Mbembe 2003: 18). These twin technologies of necropower are essential for creating the "sacrificial economy" that distributes death and illness along the categories of race and class, and the more legitimate they seem under a label of moral equality, the higher their efficiency is.

For this reason, it is necessary to step away from racial, disability, and class dimensions. They become unnecessary when treated as natural kinds – as natural as the good or bad functioning of human organs. It is not necessary, for example, to assess whether a subject has a specific respiratory condition because of a contextual history of marginalization – e.g., due to poor access to health services, adequate food, or housing. It is enough to verify that there is a respiratory malfunction. Thus, this malfunction is a sufficient reason to demand a particular resource – for example, a mechanical breathing apparatus – during a period of time considered to be "above average".[6] The act of the allocation of the resource to this subject would mean offending the titularity of others that need it for average or less than average time. This subject ceases to be a potential patient and starts to be considered as a threat to the exacerbation of the already present scarcity. That is to say: not only it is less optimal to allocate resources to certain subjects but doing so is a risk to the whole community of supposedly equal demanders.

In trying to expose the use of the ethics of resource allocation as a dispositive of necropolitics, one must remember Butler, when she asks "who counts as human? Whose lives count as lives? And […] what makes for a grievable life?" (Butler 2004: 20). One must also recall Mbembe, when he seeks to figure "under what practical conditions is the right to kill, to allow to live, or to expose to death exercised?" (Mbembe 2003: 12). These ungrievable and disposable lives, long before the Covid-19 pandemic, have been structurally discriminated through the precariousness of the accessible health system, the precariousness of policies for the realization of social rights, and the flexibilization of guarantees associated with work and social security. These measures express the functioning of racism and neoliberalism and draw the demarcation line between *those who can live and those who must die*, which coincides with the division between those who can pay and those who cannot.

[6] In allocation protocols aiming at efficiency, a calculation is made to determine the average amount of time patients will need for the resource to achieve an expected result. However, some people may require the resource to be used for a longer time in order to achieve the same result that for other patients is achieved in hours or days. The application of the "Level of Resource Commitment" principle in this case leads to allocating resources thinking that "more people can be saved with each resource if the person using it does so for a shorter period of time" (Hellman, Nicholson 2021: 1261). This means that in the case of people with respiratory diseases caused by living near factories, for example, their need for an artificial breathing machine for a period considered "long" may determine that they will not receive it.

### 3.2. Re-thinking scarcity through necropolitics: practical consequences

After reviewing scarcity under the theoretical light of necropolitics, I want to suggest four practical consequences. Even though I will not have space to develop them here – as each of them require a justification on its own – it is important to state them right away, for the sake of not repeating big words such as "neoliberalism" and "necropolitics" without actually providing possible solutions.

- 1st consequence: There is a demand for *reparation* due to the lack of preparedness for Covid-19 pandemic.
- 2nd consequence: Pandemics preparedness has to focus on the *duty to prevent scarcity* rather than on manufacturing protocols of allocation for when scarcity occurs.
- 3rd consequence: The lack of preparedness for the next pandemic must be coupled with the *State accountability*.
- 4th consequence: Discussions on pandemic preparedness must turn to *global bioethics* and must consider *world inequities related to colonial pasts*.

## Conclusion

As stated by South African writer John Maxwell Coetzee, this is a world that easily reduces people to "another brick in the pyramid of sacrifice" (Coetzee 1985: 94). Being under the threat of death is the norm in necropolitics. Prior to the beginning of the pandemic period, death was already bureaucratized and the lexicon of flattening the curve was used. The killable ones do not need to be named, since, when they die, they are, as when they were born, visible only to the censuses. The anonymity of the killable does not corroborate the assertion that there is nothing new in the politics of making die, letting die – in fact, it makes it explicit that this motto is the norm of colonial states. With the generalization of the death specter, the motto "to make die, to let die" is placed into a specific bureaucratic and theoretical frame, especially materialized in the notions of rationing policies, resource allocation protocols, and mandates for maximizing benefits. The way in which the conditions of possibility of life and death also become linked to the distribution of resources represents a fundamental bio- and necropolitical negotiation .

The scarcity of essential health resources fades into the background when the fetishized consumption of goods modulates what is seen as vital; in this sense, life is deprioritized, while ambiguously formulas of quality and optimization of life shape what we understand as vital. In this paper, I start by questioning

scarcity as a phenomenon naturally caused by the pandemic, placing it in a context of slow violence enabled by necropolitics – which is structured around the institutionalization of the exposure of bodies considered disposable to death. I sought to ask how the resources became scarce, even when we had the material means to prioritize their generation before demand exceeded supply, and we knew that, sooner or later, specific goods would become necessary to fight a global pandemic.

The more we learn about how a pandemic event has been foreseeable due to the patterns of globalization and market consumption, the more it seems clear that "fair" triage schemes may as well be a cover-up for a continuation of slow death – now more effective than ever. The precarities created by neoliberalism and the lack of planning are not accidental: they are the essence of systems that legitimize the commoditization of mortality. We are not in the same boat but on this tide those who struggle to stay afloat and those who are drowning are and will always be the same.

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