

# CALCULATING QALYS: LIBERALISM AND THE VALUE OF HEALTH STATES

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**Abstract:** The value of health states is often understood to depend on their impact on the goodness of people’s lives. As such, prominent health states metrics are grounded in particular conceptions of wellbeing – e.g. hedonism or preference satisfaction. In this paper, I consider how liberals committed to the public justification requirement – the requirement that public officials choose laws and policies that are justifiable to their citizens – should evaluate health states. Since the public justification requirement prohibits public officials from appealing to controversial conceptions of the good life, liberals committed to this principle face a significant puzzle.

**Keywords:** QALY, public justification, priority setting, health policy, liberal neutrality

Most states, if not all, enact laws and policies to ensure and promote the health of their citizens. They take public health measures, such as ensuring the safety of food, water, and housing; they implement prevention programmes to limit the prevalence of conditions such as obesity, lung cancer, and diabetes; and they provide some or all of their citizens with access to treatments, either through health insurance or the direct provision of care.

Because states take responsibility for the health of their citizens in these ways, state officials, including legislators and civil servants, face the problem of how to allocate scarce resources amongst competing health service programmes. Managers of public health insurance programmes must decide which treatments to cover; public health officials must decide how to allocate resources amongst different prevention programmes; and

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legislators face the broader problem of how to allocate public spending between treatment and prevention services.

To address this problem of allocation, such public health decision-makers (PHDMs) require a principle of just allocation, for example priority to the worse off or the principle of utility. However they also require an account of the value of different health states. By health states, I do not mean particular diseases or disabilities, but rather states of being or functioning caused by the presence or absence of disease or disability.<sup>1</sup> Health states therefore include full health or normal functioning, and departures from it, which may occur along a number of dimensions including mobility, sight, hearing, cognitive ability, pain and mood. Health state metrics assign cardinal values to health states, thus enabling PHDMs to calculate the number of quality-adjusted life years (QALYs) particular treatments can be expected to yield, or the number of disability-adjusted life years (DALYs) particular treatments can be expected to prevent. PHDMs require such a metric since they can only apply principles of allocation accurately if they have one. They can only allocate resources to maximize utility if they know the utility-measures of different health states; they can only give priority to the worse-off if they can identify which individuals are in fact worse off.<sup>2</sup> Additionally, the *choice* of metrics is important since different metrics imply different allocations of medical resources (Wolff *et al.* 2012).

In this paper, I investigate how liberals committed to the public justification requirement (PJR) should instruct PHDMs to evaluate health states. According to the PJR, state officials must choose laws and policies that are justifiable to their citizens considered as free and equal persons. The PJR is widely supported by liberal political theorists (Nagel 1991; Larmore 1996; Rawls 1996; Gaus 2011; Quong 2011); but its implications for the evaluation of health states are unclear. On the one hand, the PJR is often understood to imply *justificatory liberal neutrality*, the claim that states may not justify policies and laws by appeal to particular conceptions of the good life (Rawls 1996: 192–194; Gaus 2009: 17–19). On the other hand, the value of health states is often understood to be dependent on the degree to which they impact the goodness of people's lives (Brock 2002: 115). Liberals committed to the PJR therefore face a puzzle: how might they instruct PHDMs to evaluate health states if the

<sup>1</sup> The concepts of health, disease, and disability are highly contentious. My paper does not presuppose any particular account of health, disease or disability – e.g. the biomedical model. It only presupposes that (1) there is a distinction between health and wellbeing, and (2) distinct health states can be identified for the purposes of evaluation.

<sup>2</sup> These are not necessarily the *only* two things policymakers require to make allocation decisions. If, for example, the correct principle of allocation is fair innings, policymakers would also require information about the average age of people likely to suffer from particular diseases and disabilities.

PJR prohibits them from appealing to particular conceptions of the good life or accounts of wellbeing?

In [Section 1](#), I introduce the PJR and comment briefly on questions of motivation, scope and interpretation. Since the PJR has been defended at length elsewhere, I shall not defend it here. My paper is limited to spelling out its implications for the valuation of health states.

In [Section 2](#), I consider two prominent accounts of the value of health states and ask whether they satisfy the PJR: (1) *experienced utility metrics*, which measure the value of health states by determining the hedonic quality of the experience of persons occupying those states; and (2) *decision utility metrics*, which measure the value of health states by determining the strength of people's preferences regarding them (Dolan and Kahneman 2008: 215–216). I argue that neither satisfies the PJR since both appeal to controversial conceptions of wellbeing: hedonism in the case of experienced utility metrics, preference satisfaction in the case of decision utility metrics.

In [Section 3](#), I consider Daniel Hausman's (2015) recently formulated *activity limitation/distress metric*, according to which the value of health states is determined by (1) the extent to which they limit people's activity, and (2) the degree of pathological suffering they involve. Since Hausman (2015: 163) does not attempt to show that his metric satisfies the PJR, indeed arguing that the pathological suffering component is grounded in the state's duty of compassion and care, I first investigate whether free and equal citizens have sufficient reason to accept the claim that the badness of health states is determined by (1) and (2). I argue that they do, and so conclude that Hausman's metric satisfies the PJR.

In [Section 4](#) however, I argue that Hausman's metric does not offer as clear an alternative to decision utility metrics as Hausman claims. First, I suggest that decision utility metrics need not be understood as grounded in a preference satisfaction account of wellbeing, but can instead be understood as fair procedures for adjudicating citizens' reasonable disagreements concerning the nature of the good life – an understanding that, as I show below, is much friendlier to the PJR. Second, I argue that Hausman is wrong to think that it is possible, within the framework of his metric, to evaluate health states without appealing to controversial conceptions of the good life. I suggest instead that in certain circumstances, Hausman's metric and decision utility metrics are unlikely to yield significantly different health state valuations. For both of these reasons, I conclude that liberals committed to the PJR have reason to see decision utility metrics as sufficiently liberal – i.e. a legitimate second-best alternative.<sup>3</sup>

<sup>3</sup> One limitation of my paper is that I only consider health states metrics that are *well-developed*. By a well-developed health states metric, I mean a metric (1) that is normatively

## 1. THE PUBLIC JUSTIFICATION REQUIREMENT

The PJR holds that public officials ought to pass laws and policies that are justifiable to the public that they serve. A law or policy is justifiable to the public if and only if each member of the public has sufficient reason(s) to endorse it.<sup>4</sup> A member of the public has sufficient reason(s) to endorse a particular law or policy if she is *rationally committed* to endorsing it. Whether a law or policy is justifiable to members of the public does not therefore depend on whether they would *actually* endorse it.

Scholars generally motivate the PJR by arguing that public officials must comply with it if they are to respect members of the public qua free and equal persons. Some argue that public officials' use of *coercion* is respectful of members of the public if and only if this power is used in ways that are rationally acceptable to them (Nagel 1991: 36–37; Rawls 1996: 136–137; Gaus 2009: 206–208; Quong 2011: 1–2). Others argue that public officials' *acting on behalf of* members of the public is respectful of them qua free and equal persons if and only if officials do so in ways that members of the public could endorse as free and equal legislative co-authors (Bird 2014: 201–204).

Scholars committed to the PJR disagree on important matters of interpretation and scope. First, for a law or policy to satisfy the PJR,

well-grounded, and (2) for which there is a clear plan regarding implementation. As will become clear below, experienced utility metrics, decision utility metrics, and Hausman's activity limitation/distress metric satisfy these conditions. Health states metrics grounded in the capability approach however, do not, and so I do not consider whether such metrics could satisfy the PJR. While health economists have made impressive strides towards developing a health states metric that operationalizes the capability approach, these approaches face significant implementation challenges; and they treat the capability approach as a formal structure – i.e. they do not outline the *specific* capabilities by which health states should be evaluated (Cookson 2005; Bleichrodt and Quiggin 2013). As such, these metrics do not attempt to operationalize the normatively well-grounded versions of the capability approach that have been developed for the context of health policy, and so fail to satisfy condition (1) (Nussbaum 2001; Ruger 2010; Venkatapuram 2011). In addition, to my knowledge, there is no clear plan for the development of these latter normatively well-grounded accounts of the capability approach into a health states metric capable of yielding QALY values. Since these accounts are multidimensional, listing multiple capabilities relevant to health policy, this task is a difficult one, and some scholars have questioned the possibility and/or wisdom of operationalizing these accounts in this way (Wolff *et al.* 2012: 461; Hausman 2015: 147). For example, the recently developed OxCAP-MH tool, which employs Nussbaum's list of 10 basic capabilities to measure outcomes in mental health research, does not generate QALY values, and its developers argue explicitly against developing it in that direction (Simon *et al.* 2013: 195). Coast *et al.* (2015) offer a good overview of the problems and prospects of developing a health states metric grounded in the capability approach.

<sup>4</sup> This version of the PJR is derived from Kevin Vallier and Fred D'Agostino's (2014) formulation of this principle, a formulation that aims to be a 'master' principle for the family of 'public reason liberal political theories'.

must members of the public accept it on the basis of *public* reasons – i.e. reasons they can reasonably expect other citizens to share (Rawls 1996: 213–227; Quong 2011: 261–273); or, can they accept it on the basis of *private* reasons – i.e. reasons they cannot reasonably expect other citizens to share (Vallier 2011)? Second, are public officials only *state* officials, or can they also be officials of international agencies such as the various arms of the United Nations? Similarly, must members of the public be co-citizens, or does the international community at large constitute a public in some important respects? Third, what is the scope of the PJR? Does it only apply to questions of constitutional rights and basic questions of justice (Rawls 1996: 227–230), or, does it apply to all spheres of public policy (Quong 2011: 273–287)? Finally, for a law or policy to satisfy the PJR, is it enough that members of the public have sufficient reason to accept it when it is formulated in very general terms – i.e. as a set of principles (Nagel 1991: 33; Rawls 1996: 136–137)? Or, must all members of the public have sufficient reason to accept it in all its detail?

Fortunately, I need not resolve all of these questions to determine the implications of the PJR for the evaluation of health states. Regarding the issue of scope, my analysis presupposes that the PJR applies to questions of priority setting in health; but, this presupposition is a reasonable one. First, although Rawls limits the PJR to questions of ‘constitutional essentials’ and ‘basic questions of justice’, the question of health care resource allocation would seem to qualify as a basic question of justice. Although Rawls (1996: 21, 223–230; 2001: 174) abstracts away from the problem of health care in *Political Liberalism*, he understands basic questions of justice to include those of social and economic equality, of which health care allocation is clearly an example, and also makes clear in *Justice as Fairness* that the question of health care falls within the scope of a political conception of justice.

Regarding the question of which institutional officials count as public officials and whether the international community constitutes a public, my analysis has important implications even if these questions are answered in the narrowest way possible – i.e. that public officials are only officials of a domestic state and that the public they serve are state residents. As I note above, state PHDMs face important questions of resource allocation in health care and so even if the PJR only applies to state officials, determining its implications for the evaluation of health states would still be a significant contribution. As well, I need not adjudicate the question of public vs. private reasons since it is public reasons that are typically offered in favour of different health states metrics.

My analysis *does* depend on the question of whether the PJR only requires that policies or laws be acceptable to members of the public when formulated as general principles, or whether it requires that citizens have sufficient reason to endorse all aspects of a particular law or policy. As

I discuss in [Section 4](#), Hausman's metric satisfies the PJR on the former interpretation, but not the latter.

Are there cases where there is *no* law or policy that citizens have sufficient reason to endorse? Yes. In these cases, citizens *reasonably disagree* about a law or policy. By a reasonable disagreement here, I follow Rawls (1996: 54–58) in meaning a disagreement by two or more persons that is not the result of errors in reasoning, bias, or stupidity, but that is consistent with each person exercising her rational capacities in a conscientious way. Where citizens reasonably disagree about a law or policy, public reasoning about a policy or law is *inconclusive*: it does not imply a conclusion that all citizens have sufficient reason to endorse (Gaus 2003: 215–216).

In cases where public reasoning is inconclusive, should the PJR be interpreted to require that governments not act to address the policy problem in question? Not necessarily. It is important to distinguish cases where citizens reasonably disagree about whether government should regulate a specific sphere of activity, from cases where all citizens have sufficient reason to regulate a specific sphere of activity but reasonably disagree about which particular regulations should be implemented (Nagel 1991: 164–165; Gaus 2003: 216). In cases of the former type, it is reasonable to think that government should not act since not all citizens have sufficient reason to think that government action is warranted (Nagel 1991: 164–165; Gaus 2003: 216).

In cases of the latter type however, government action is sufficiently respectful of citizens qua free and equal persons. First, all citizens have sufficient reason to endorse government regulation of some kind. Second, governments can choose policies in these types of cases in a way that is respectful of citizens, namely, through deliberative democratic procedures. Such procedures demonstrate respect for citizens qua free and equal persons since they provide them with the opportunity to reason publicly about the possible policy options, and grant them an equal say regarding the policy that will be chosen (Nagel 1991: 163; Gaus 2003: 218–221). In these types of cases therefore, although citizens do not have a sufficient reason to endorse one particular policy or law, they do have sufficient reason to endorse a deliberative democratic procedure as a way of choosing a policy or law (Nagel 1991: 163; Gaus 2003: 218–221). My analysis proceeds on the assumption that citizens have sufficient reason to accept at least some health-related government regulation, making the valuation of health states a problem for PHDMs.

In sum, according to the PJR, public officials ought to pass laws and policies that are justifiable to the public. In cases where no policy satisfies the PJR, but citizens have sufficient reason to accept that some government action is required, the policy should be chosen through deliberative democratic procedures. In what follows, I investigate whether citizens have sufficient reason to accept any of the three health states metrics identified above.

## 2. EXPERIENCED UTILITY METRICS AND DECISION UTILITY METRICS

Experienced utility metrics measure the value of health states by determining the hedonic quality of experience of persons living in those states (Dolan and Kahneman 2008: 215). The quality of this experience is measured by compiling reports of the experienced utility or subjective satisfaction of persons in particular health states. This can be done by having such individuals rate the quality of their feelings at random times of day – experience sampling – or complete diary entries detailing the quality of the previous day's experiences – daily reconstruction (Dolan and Kahneman 2008: 228–229).

Proponents of the experienced utility approach rightly understand it to be grounded in sensory hedonism (Dolan and Kahneman 2008: 215), the view that the good life is the pleasant life, where pleasures are understood to be certain feelings or sensations – i.e. experiences – having positive affect (Feldman 2004: 55). This understanding of the experienced utility approach provides it with its strongest justification since health is normatively significant primarily because of the way in which it affects people's wellbeing. For this approach therefore, the value of health states is determined by the quality of experience that they promise.

Because the experienced utility approach presupposes sensory hedonism however, some citizens do not have sufficient reason to endorse it. Citizens can reasonably disagree about whether sensory hedonism is the correct account of wellbeing. This is not to deny that sensory pleasures contribute to the goodness of many lives, and, as I shall argue below, pain caused by disease or disability does diminish the quality of people's lives. However, it is reasonable to think that the value of many projects is not solely determined by the quality of experience that they promise. For many, marathon running, backcountry camping, completing a PhD in philosophy, or raising children are deeply valuable projects, despite the fact that they often promise little sensory pleasure and a good deal of pain – e.g. stress, anxiety and physical discomfort.<sup>5</sup> These citizens are not therefore rationally committed to endorsing the experienced utility approach since they can reasonably object that wellbeing depends on factors other than the quality of one's experience.<sup>6</sup> Experienced utility metrics do not therefore satisfy the PJR.

Decision utility metrics would seem to avoid this problem with experienced utility metrics since they allow health states to be evaluated

<sup>5</sup> This problem with sensory hedonism is widely acknowledged in the literature (Nozick 1975: 42–45; Hausman 2010: 328–329; Dorsey 2011: 177–182).

<sup>6</sup> Roger Crisp (2006: 639) offers what I take to be the strongest response to this line of argument, pressing non-sensory hedonists to identify the features of these projects – other than pleasure – that contribute to an individual's wellbeing. In my view, Dorsey (2011: 190–193) offers a compelling objection to Crisp's response.



by considerations other than quality of experience. Instead, these metrics measure the value of health states by determining the strength of people's preferences to avoid occupying them. These preferences can be elicited by means of a number of methods that enable the assignment of cardinal values, including rating scales, standard gambles and time trade-offs (Torrance 1986: 18–20).<sup>7</sup>

The most promising justification for decision utility metrics is that wellbeing consists in the satisfaction of preferences. On this view, a person's life goes well to the extent that her preferences for different outcomes or states of affairs are satisfied (Griffin 1986: 10). By eliciting and measuring the strength of people's preferences to avoid particular health states, decision utility metrics determine the extent to which different health states can be expected to impact people's wellbeing (Dolan and Kahneman 2008: 215–216; Hausman 2006: 259). The value of different health states is determined by the strength of people's preferences to avoid occupying them.

Unfortunately, citizens can reasonably disagree about whether wellbeing consists in the satisfaction of preferences. As such, some citizens are not rationally committed to accepting decision utility metrics. The problem is that it is reasonable to think that the satisfaction of preferences is neither sufficient nor necessary for wellbeing.

First, it is reasonable to think that the satisfaction of preferences is not sufficient for wellbeing since people are not always made better off by the satisfaction of their preferences. The chief problem is that people may have false beliefs about the state of affairs or outcomes for which they form preferences. Suppose I grow up in a small town and, seduced by the movies of Woody Allen, formulate a strong preference to live in New York City. Upon arriving however, I am shocked by the cost of living, the constant noise, and the sheer busyness that life in New York City offers, facts that I was either previously unaware of, or failed to appreciate fully. As a consequence, I quickly return home to my small town. It seems counter-intuitive to claim that satisfying my preference to live in New York City improved my wellbeing.<sup>8</sup> This is a problem for decision utility

<sup>7</sup> The person trade-off tool is not an example of a decision utility metric since it is not designed to evaluate health states, but rather to measure the societal value of particular health interventions, considering both the impact of such interventions on people's health, and questions of fairness in allocation (Nord 1999: 115–118). The person trade-off tool therefore presupposes some measure of the degree to which particular interventions improve people's health; and some scholars estimate this degree of improvement through the use of a decision utility metric – i.e. understanding improvements in health in terms of QALYs gained (Ubel *et al.* 2000).

<sup>8</sup> This is a common objection in the literature (Griffin 1986: 10–13; Sobel 1994: 788–789; Sumner 1996: 129–130; Arneson 1999: 113–142; Hausman and McPherson 2009: 6; Lauinger 2011: 324–327).



metrics moreover since many people are likely to have false beliefs about what it is like to occupy certain health states (Hausman 2015: 85–90).

It is also reasonable to think that the satisfaction of preferences is not necessary for wellbeing. My wellbeing can be improved by states of affairs for which I have formulated no antecedent preference. Consider pleasant surprises:

Having never heard bluegrass, I chance on a band playing in the park and find that I like it. Having nursed a longstanding suspicion of the Mediterranean, I am persuaded against my better judgment to holiday there and have a wonderful time. In neither case did I have an antecedent desire for the state of affairs which, as it turns out, enhances my well-being. (Sumner 1996: 133)

It is reasonable to think therefore that the satisfaction of preferences is neither necessary nor sufficient for wellbeing. If the argument in support of decision utility metrics is that preference satisfaction constitutes wellbeing, and so decision utility metrics, by measuring the strength of people's preferences to avoid occupying particular health states, determine the impact of health states on people's wellbeing, some citizens do not have sufficient reason to accept these metrics.

Proponents of preference satisfaction accounts respond to these lines of argument by modifying their view, claiming that wellbeing consists in the satisfaction of *informed* preferences. On this view, one's wellbeing is determined by the satisfaction of the preferences one would have if one occupied a privileged epistemic standpoint – i.e. had unconstrained access to all of the relevant information concerning the goods and lives one must choose amongst (Griffin 1986: 11; Railton 1986: 16; Sobel 1994: 790; Rawls 1999: 358–372). By occupying such a privileged epistemic standpoint, one can consider what it would be like to live one's life in different ways (Sobel 2009: 344). Moreover, it is arguable that decision utility metrics can be modified to accord with this view – to some extent – if respondents are provided with information regarding the health states they are asked to evaluate (Hausman 2015: 89–90).

Although I am sympathetic to the view that wellbeing is constituted by the satisfaction of informed preferences, scholars have raised a number of plausible objections to it. The problem with this view, according to these critics, is that the informed preference account is purely procedural. It does not therefore rule out cases where people's informed preferences are satisfied, but their lives seem intuitively poor in wellbeing; and it does not rule out cases where people's informed preferences are not satisfied, but their lives seem intuitively rich in wellbeing. Consider John Rawls's (1999: 379–380) case of the grass-counter as an example of the former type of case:

imagine someone whose only pleasure is to count blades of grass in various geometrically shaped areas such as park squares and well-trimmed lawns. He is otherwise intelligent and actually possesses unusual skills, since he manages to survive by solving difficult mathematical problems for a fee. The definition of the good forces us to admit that the good for this man is indeed counting blades of grass ... if we allow that his nature is to enjoy this activity and not to enjoy any other, and that there is no feasible way to alter his condition, then surely a rational plan for him will center around this condition.

Some scholars find it deeply counter-intuitive to claim that the grass-counter is living a life rich in wellbeing and this skepticism strikes me as reasonable (Arneson 1999; Crisp 2015; Parfit 2011: 75–82).

Some citizens can therefore reasonably object to the use of decision utility metrics when these metrics are grounded in the claim that preference satisfaction is the correct account of wellbeing. But, there is another justification for these metrics. As I argue above, in cases where public reasoning regarding a policy is inconclusive but where there is agreement that some policy is necessary, the PJR implies that government should choose a policy by means of a deliberative democratic procedure. It is arguable that suitably designed decision utility metrics can operate as such a procedure for the purposes of evaluating health states since they involve citizens directly evaluating health states. Indeed, decision utility metrics, insofar as they determine the value of health states by incorporating and averaging the health-related preferences of a representative sample of people, can be understood as a democratic procedure that gives equal weight to each person's conception of wellbeing. Decision utility metrics, after all, allow hedonists to evaluate health states by reference to the hedonic quality of experience of people in those states. They allow perfectionists or those holding objective list views of wellbeing to determine the value of health states by reference to the substantive goals and projects that they deem to be valuable. And, they allow people to determine the value of health states by reference to the values and preferences they take to be constitutive of a good life. If playing soccer is my favourite activity, I can rate health states that involve the loss of a foot very low. If I prefer intellectual activities to physical ones, I can rate health states involving loss of cognitive capacity lower than those involving loss of physical capacities.

However, before concluding that decision utility metrics – understood as democratic procedures – are best from the standpoint of the PJR, we need to first establish that public reasoning regarding the value of health states is indeed inconclusive. I argue below that this conclusion is not warranted.

### 3. HAUSMAN'S ACTIVITY LIMITATION/DISTRESS METRIC

In his recent book, *Valuing Health: Well-Being, Freedom, and Suffering*, Daniel Hausman defends what I shall refer to as the Activity Limitation/Distress (AL/D) metric. On Hausman's (2015: 155) view, the value of health states should be determined by: (1) the extent to which these states limit the freedom or activities of people; and (2) the pathological suffering they involve.

Hausman's (2015: 158–159) central justification for this metric is that the value of health that matters to health policy is not the 'private value' of health, that is, the value of health to people's individual wellbeing; but rather the 'public value' of health, that is, the value of health to the public. Since the purpose of the liberal state, Hausman (2015: 159–160) argues, is not to promote private views of the nature of wellbeing or the good life, government policy ought not to be governed by such views. The central responsibility of the liberal state, Hausman (2015: 160) argues, is instead to 'protect rights, secure justice, to address need and suffering, to expand opportunities, and to insure individuals against catastrophes, even of their own making'. A state that successfully fulfils this responsibility, Hausman (2015: 161) claims, is a '*liberal facilitator state*'.<sup>9</sup>

Since the liberal facilitator state must be largely neutral amongst private views of the good life or wellbeing, focusing instead on expanding 'the range of personal choices that are open to its citizens', the public value of health states should depend on the extent to which particular diseases and disabilities limit the *activity* of individuals (Hausman 2015: 163). Since the chief responsibility of the liberal state is to facilitate the activities of its citizens, the public valuation of health states should be based on the extent to which particular health states limit these activities (Hausman 2015: 163). Additionally, Hausman (2015: 163) claims, because the liberal state also has duties of care and compassion, it has a legitimate role in 'reducing suffering'. For this reason, the public value of health states should also depend on the suffering that these states involve (Hausman 2015: 164). With respect to health policy therefore, Hausman (2015: 166) defends the position he calls 'benevolent liberal facilitation':

State health policy has a dual mandate. As liberal, state health policy should aim to lessen activity limitations, and, as benevolent, health policy should aim to alleviate pathological suffering.

Hausman's AL/D metric, partially grounded as it is in the idea of liberal neutrality, is promising from the standpoint of the PJR. As I note above, the idea of liberal neutrality is often understood to be grounded in the

<sup>9</sup> As Hausman (2015: 145–146) himself notes, Norman Daniels (1985) was the first scholar to offer a liberal theory of the value of health, arguing that it is normatively significant because of the way in which disease and disability can limit people's opportunities.

PJR. However, Hausman (2015: 160) does not attempt to show that his approach satisfies the PJR, relying instead on the general idea that the purpose of the liberal state is to 'preserve and enlarge the possibilities for the successful pursuit of a wide range of individual goals, rather than joining state power to the efforts of individuals to enable them to reach their goals'. Additionally, the suffering component of Hausman's metric is not justified by appeal to the idea of liberal neutrality, but instead by appeal to the state's duty of compassion. Thus, even if one were tempted to accept the claim that the *activity* component of Hausman's metric satisfies the PJR, Hausman provides no reason to think that the *suffering* component of his metric does so.

In what follows therefore, I first outline Hausman's AL/D metric. I then investigate whether it satisfies the PJR.

### 3.1. What is Hausman's AL/D Metric?

Hausman's AL/D metric claims that the value of health states should be determined by (1) the extent to which they limit people's activities; and (2) the pathological suffering they involve. By 'pathological suffering', Hausman (2015: 171) means the physical discomfort – e.g. negative sensations such as pain or nausea – or emotional distress – e.g. negative mental states such as depression or panic – that are component parts of health states, not reactions to them. Hausman recognizes that it is likely impossible to construct a complete, fine-grained ranking of the possible forms and combinations of physical discomfort and emotional distress. But, he suggests that a complete ordering of health states with respect to the disvalue of pathological suffering is possible if these states are sorted into a small number of broad categories such as: 'severe suffering, moderate suffering, mild suffering, or little or no distress' (Hausman 2015: 172). Such a coarse ordering of health states, Hausman (2015: 172) claims, is likely to be sufficient for the purposes of priority setting.

To measure the extent to which health states limit people's activity, Hausman (2015: 176) proposes that health states be ordered in terms of the following classification of activity limitations:

1. Not limited.
2. Minor social or occupational limits.
3. Major social or occupational limits.
4. Physically limited in IADL.
5. Physically limited in ADL or cognitively limited in IADL.
6. Cognitively limited in ADL.

By social or occupational limits, Hausman (2015: 176) means 'limits on the range of occupations, recreations, and social relations that are

available to the individual as a consequence of their health'. The social and occupational activities in question are those available to people generally in their society, and do not refer to specific activities or projects individuals have chosen to pursue (Hausman 2015: 176). ADL – activities of daily living – include: 'eating, getting in/out of bed, inside mobility, dressing, bathing, and toileting' (Hausman 2015: 174). IADL – instrumental activities of daily living – include: 'light housework, laundry, meal preparation, grocery shopping, outside mobility, travel, money management, and telephoning' (Hausman 2015: 174). Hausman (2015: 176) classifies cognitive limits as more severe than physical limits since people who are physically incapable of performing ADL or IADL may still be cognitively capable of engaging in a variety of intellectual activities. Those who are severely cognitively disabled, by contrast, are unable to direct their lives.

Hausman does not commit himself to the specific categories he proposes – he recognizes that research may demonstrate that different classification systems may prove to be more accurate and intuitive. But, Hausman's system provides a framework for classifying different health states in terms of (1) the extent to which they limit people's activity; and (2) the pathological suffering they involve:

Activity limitation	Distress			
	Okay	Mild Suffering	Moderate Suffering	Severe Suffering
Not limited	1.0			
Minor social or occupational limits				
Major social or occupational limits				
Physically limited in IADL				
Physically limited in ADL or cognitively limited in IADL				
Cognitively limited in ADL				

Particular health states can be understood as 'limitation/distress (L/D) pairs', with the above chart allowing decision-makers to map particular health states onto one of the 24 cells (Hausman 2015: 177). Each cell would then be assigned a QALY value from 0 to 1, with 1 indicating full health.

The central challenge for Hausman's (2015: 179) approach is to assign these QALY values in a principled way, thus constructing a 'cardinal scalar measure of the public value of limitation/discomfort pairs'. To construct such a measure, Hausman must not only determine the value, on scales of 0 to 1, of the different categories of activity limitation and distress he identifies above, but also combine these scales into a single

metric, making it possible to compare the value of health states that limit activity but involve no distress and vice versa, and assign values to health states that limit activity and involve distress. As Hausman (2015: 180) recognizes, this involves answering a number of difficult normative questions: should the worst possible health state be assigned a 0, or is such a state worse than death? Should increases in activity limitation always yield the same decline in QALY value, regardless of the level of distress and vice versa (Hausman 2015: 180–181)? If the answer to this question is affirmative, how should numbers be assigned to the gaps between different categories of activity limitation and different categories of distress (Hausman 2015: 181)? This last question is particularly difficult, requiring one to compare the disvalue of activity limitations to the disvalue of different levels of distress.

Hausman (2015: 180–186) provides an illustration of how one might answer these questions that appeals to public, not private, values; but, he admits that his account is inconclusive. He claims therefore that the assignment of values to limitation/distress pairs should ultimately be left to a public procedure, whether this takes the form of public deliberation, public surveys, or citizen juries (Hausman 2015: 186–187).

### 3.2. Does Hausman's Metric Satisfy the PJR?

To determine if Hausman's approach satisfies the PJR, I first investigate whether citizens have sufficient reason to accept the claim that freedom and the absence of pathological suffering are valuable. I then turn to the question of whether Hausman's metric can be understood to satisfy the PJR.

3.2.1. *The value of freedom.* According to Hausman (2015: 160–166), the value of health states should be determined, in part, by the extent to which they limit the range of activities people can engage in, not the extent to which they limit people's ability to realize the goals or projects they currently deem to be valuable. The value of health states should thus be determined, in part, by the extent to which they limit people's freedom, where by freedom, I mean the capacity to set and pursue goals and projects on the basis of reasons.<sup>10</sup> Freedom thus involves the cognitive and emotive abilities necessary to deliberate about the goodness of ends, but also the physical ability to realize them. Hausman's specification of the

<sup>10</sup> Although *freedom* is in the title of Hausman's book, Hausman uses the terms *activity* and *opportunity* to a much greater extent. Since Hausman (2015: 158–162, 215) uses these three terms interchangeably and since *freedom* is the most natural term to use in the discussion that follows, I largely use this term below.

categories of activity limitation thus includes limits to people's physical and cognitive abilities.

If the activity component of Hausman's AL/D is to satisfy the PJR, citizens must have sufficient reason to accept the claim that freedom is *non-specifically* valuable. Freedom is non-specifically valuable if and only if it is valuable as such, that is, valuable independently of the activities and projects it enables people to realize that they *currently* specify to be valuable (Carter 1999: 33).<sup>11</sup> Only if citizens have sufficient reason to endorse the claim that freedom is non-specifically valuable might they have sufficient reason to endorse the claim that the value of health states ought to be determined, at least in part, by the extent to which they limit the range of activities they can engage in.

I argue here that citizens do have sufficient reason to endorse the claim that freedom is non-specifically valuable. I defend this claim by means of a two-step argument. I argue first that citizens can be reasonably expected to accept that they have an interest in setting and pursuing that plan of life that they take themselves to have reasons to pursue. I argue second that since freedom is instrumental to, and a constitutive part of, the realization of this interest, citizens can be reasonably expected to accept that freedom is non-specifically valuable. Freedom is important for the realization of this interest, I argue, because reasonable people recognize that they are fallible about the nature of wellbeing or the good life. Freedom enables us to revise our plan of life when we take ourselves to have reasons to do so and thus pursue that plan that we take ourselves to have reasons to pursue.<sup>12</sup>

Consider first that although citizens of pluralistic societies reasonably disagree about the nature of the good life, they nonetheless take themselves to have an interest in pursuing the conception of the good life that they hold. After all, to hold such a conception is simply to think that some projects and activities are worth pursuing or engaging in. To say that citizens take themselves to have an interest in pursuing the plan of life that they hold is therefore just to say that they understand what it means to take some projects to be good and are self-conscious of the fact that they do so.

Consider second that people do not hold their conceptions of the good life willy nilly. Instead, they do so because they take themselves to have reasons to think that a particular plan of life is good. My claim here is a phenomenological one. Because we are self-conscious, reflective beings, we are not simply dominated by our perceptions and desires with

<sup>11</sup> The non-specific value of freedom is thus analogous to the value of money. Money is not only valuable because it enables us to purchase the goods and services that we currently identify as valuable, but also because it enables us to purchase goods and services that we may take to be valuable in the future (Carter 1999: 36).

<sup>12</sup> Carter (1999: 50–52) presents a condensed version of this argument.



respect to the formation of beliefs, the performance of particular actions, or the pursuit of particular plans of life (Korsgaard 1996a: 93). Instead, we possess the capacity to distance ourselves from our perceptions and desires, that is, to reflect on them (Korsgaard 1996a: 93). To form a belief or choose an action therefore, we must bring the process of reflection to a close by taking ourselves to have a *reason* to form one belief rather than another, or perform one action rather than another (Korsgaard 1996a: 93). Of course, there are times when we simply act – e.g. in moments of great danger. However, when we face decisions of what career to pursue, whether to start a relationship, or what to do with our free time, we find ourselves in this reflective space, requiring a reason to decide one way or the other.

In making this claim, I do not mean to imply that people always decide what to do with their lives on the basis of long chains of argumentation. By a reason, I mean something very minimal, namely a consideration in favour (Scanlon 1998: 17). My reason for choosing to play soccer on Sunday afternoon rather than read may simply be that I find the former to be more fun than the latter, or that I read on the couch yesterday. Nor am I denying that the reasons people take themselves to have are sometimes bad reasons; that people sometimes fail to act in accordance with what they take to be their strongest reasons; or that they sometimes do not thoroughly evaluate the strength of their reasons. My claim is rather that people make plan-of-life-relevant decisions on the basis of what they take to be reasons, and hold their particular conception of the good life because they understand themselves to have reasons to do so.

With respect to conceptions of the good life therefore, citizens can be reasonably expected to accept that they each have an interest in setting and pursuing that plan of life that they take themselves to have reasons to set and pursue. This implies further that citizens have sufficient reason to accept the claim that freedom is *specifically* valuable, both *constitutively* and *instrumentally*.<sup>13</sup> Citizens are committed to this claim since exercises of freedom are *constitutive parts* or *logically necessary conditions* of realizing their interest in setting and pursuing the plan of life that they take themselves to have reasons to set and pursue. This is so since freedom, as I define it above, simply is the capacity to set and pursue a plan of life on the basis of reasons. Citizens also have sufficient reason to accept the claim that specific exercises of freedom are *instrumentally* valuable since such exercises are not only *constitutive parts* of setting and pursuing particular plans of life, but also the *means* of doing so (Carter 1999: 44).

<sup>13</sup> Freedom is constitutively valuable if it is a constitutive part or logically necessary condition of the realization of some other valuable goal or activity (Carter 1999: 55).

Citizens can also be reasonably expected to accept that freedom is *non-specifically* valuable, both constitutively and instrumentally. This is so because reasonable people recognize that they are fallible. They recognize that their plan of life is subject to rational reflection, that they may be mistaken about which life is best, and so that they may have reason to pursue a different plan of life in the future. To realize their interest in setting and pursuing that plan of life that they take themselves to have reason to set and pursue therefore, citizens must not only be able to exercise their freedom in the *specific* ways demanded by the particular activities they hold to be good, but also in the *diversity* of ways required by those activities they may take themselves to have reasons to pursue in the future. Since freedom is not only a constitutive part of, and means to, the setting and pursuing of one's *current* plan of life, but also any *future* plans one develops, citizens are therefore committed to the claim that freedom is non-specifically valuable, both constitutively and instrumentally.

Citizens therefore have sufficient reason to accept the claim that freedom is non-specifically valuable. They therefore have sufficient reason to accept the first component of Hausman's AL/D metric. I turn next to the second component: pathological suffering.

*3.2.2 The Disvalue of Pain.* The claim that pathological suffering is bad is intuitively compelling. It is also no doubt widely held amongst citizens of liberal democracies. A central purpose of medical practice, after all, is to relieve the suffering caused by disease and disability. Additionally, there are two persuasive lines of argument that support this claim.

On the first, pathological suffering is bad since pain is *intrinsically* bad (Goldstein 1989; Rachels 2000). Proponents of this view argue that it is simply self-evident that pain is intrinsically bad, and challenge potential objectors to point to a counter-example. In response to those who point out that pain is necessary if creatures like us are to successfully avoid threats in our environment, or that episodes of painful disease or disability can sometimes make one's life go better, proponents of this view argue that these examples only show that pain can sometimes be *instrumentally* good. In response to those who claim that pain is a necessary component of some valuable activity – e.g. marathon running or boxing – they argue that this only shows that pain can sometimes be *constitutively* good. Finally, in response to masochists who claim that pain is intrinsically good, they argue that any plausible understanding of the phenomena of masochism implies that this claim is false (Seligman 1970: 71; Goldstein 1989: 264).

On a second line of argument, pathological suffering is bad since pain is *extrinsically* bad, where something has extrinsic value or disvalue if the value or disvalue it has is derived from something external to it (Korsgaard 1996b: 250). Seana Valentine Shiffrin (2012) adopts something like this view on the badness of pain in the context of a discussion of

the nature of harm. Pain, Shiffrin (2012: 383) suggests, is bad because it frustrates and impedes people's autonomous will. It does so both by disabling those cognitive and physical powers necessary for autonomous functioning and distracting us from fully engaging in our projects; but also by simply forcing itself on our consciousness, imposing an experience on us at odds with our will that we must passively endure. The badness of pain, or, as Shiffrin puts it, its nature as a harm, can be limited in cases where it is chosen as a component of some valuable activity. However, because pain traps one in an experience to which one is 'passive and resistant instead of being actively engaged and identified with' and so always involves an estrangement between one's will and one's experience, its extrinsic badness cannot be eliminated (Shiffrin 2012: 383).

Others hold that pain is extrinsically bad not because it frustrates or impedes individuals' autonomous will but instead simply because people dislike it. The disvalue of pain, on this view, is extrinsic, since its disvalue is derived from the intrinsic disvalue of having a mental state that one dislikes (Brandt 1998: 132; Parfit 2011: 52–56). One might think that this understanding of the disvalue of pain raises the possibility of a counterexample to the claim that pathological suffering is bad. After all, such pain would be good, on this account, if someone liked it. However, although such a preference is a logical possibility, it is difficult to imagine a competent person in fact holding it. Such a person would like the painful sensations caused by her disease or disability not because they are a means to some greater good, but for themselves.

*3.2.3. The AL/D Metric and the PJR.* Citizens therefore have sufficient reason to accept the claim that freedom and the absence of pathological suffering are valuable. It would seem to follow that citizens also have sufficient reason to accept Hausman's AL/D metric since it evaluates health states in terms of these two factors. However, one might resist drawing this conclusion.

First, one might argue that although citizens have sufficient reason to accept the claim that freedom and the absence of pathological suffering are valuable, there may be reasons to think that one or both of these factors are not relevant to health policy.<sup>14</sup> Second, one might argue that citizens do not have sufficient reason to accept Hausman's metric because it leaves out some further factor that ought to be an object of health policy.<sup>15</sup>

Finally, one might argue that citizens do not have sufficient reason to accept Hausman's metric since citizens can reasonably disagree about how to assign QALY values to limitation/distress pairs. As I note above, Hausman himself claims that public reasoning regarding this question is

<sup>14</sup> I thank an anonymous reviewer for raising this objection.

<sup>15</sup> I thank Tina Rulli and an anonymous reviewer for raising this objection.

likely to be inconclusive since there are many reasonable ways to weigh the values of freedom and the absence of pathological suffering.

In response to the first problem, it is difficult to imagine a reason why either freedom or the absence of pathological suffering is not a legitimate object of health policy. The latter in particular is traditionally understood to be a primary goal of the practice of medicine. Additionally, as Hausman (2015: 145–147) makes clear, the goal of facilitating citizens' activity is often appealed to by prominent approaches to health justice – including Norman Daniels's opportunities-based account and the capabilities approach – to justify public health interventions and the provision of health insurance.

In response to the second problem, I grant that I have not shown that the values of freedom and the absence of pathological suffering are the *only* values citizens have reason to accept for the purposes of valuing health states. But, I don't think this implies that Hausman's metric does not satisfy the PJR. First, it is very difficult to imagine a further, publicly justifiable value. Given that I address hedonism and preference satisfaction above, the obvious candidate would be some particular perfectionist value. But, a chief objection to such values is that they are controversial, and so not publicly justifiable. One might also point to the capabilities approach, perhaps arguing that there is some specific capability that could satisfy the PJR. But, any such capability that can avoid taking the form of a perfectionist value is likely to be already captured by Hausman's metric.

Second, in the absence of an argument showing that citizens have sufficient reason to accept some third value, it does not seem unreasonable to conclude that citizens have sufficient reason to accept Hausman's AL/D metric. If proving a negative were necessary to show that a policy satisfies the PJR, very few policies would satisfy it.

Finally, regarding the third problem, I grant that citizens do not have sufficient reason to accept Hausman's AL/D metric, considered in its entirety, as a policy of health state evaluation. But, it would be a mistake to conclude that Hausman's AL/D metric is no different from experienced utility and decision utility metrics from the standpoint of the PJR.

In contrast to these metrics, citizens have sufficient reason to accept the values underlying Hausman's AL/D metric, namely, the values of freedom and the absence of pathological suffering. This difference is important since, as I note above, there is some debate about what it means for a policy to satisfy the PJR. Is it sufficient that a law or policy, formulated in general terms as principles, is acceptable to citizens? Or, must all members of the public have sufficient reason to accept the law or policy in all its detail? It's clear that Hausman's metric does not satisfy the PJR on the latter interpretation since reasonable disagreement is possible regarding the assignment of QALY values to limitation/distress pairs. But,

Hausman's metric does satisfy the PJR on the former interpretation. This is so since citizens have sufficient reason to accept the basic principles that are constitutive of Hausman's metric.

There is reason to think, moreover, that the former interpretation of the PJR is more plausible than the alternative. If a policy satisfies the PJR only if all citizens have sufficient reason to accept it in all its detail, no policy would ever satisfy the PJR. After all, policies and laws in contemporary liberal democracies are often hundreds of pages in length. For this reason, scholars committed to the PJR largely adopt this interpretation and focus on showing that general principles such as freedom of speech, freedom of religion, and private property are justifiable to citizens (Rawls 1996; Gaus 2003: 214–218). These scholars recognize that the precise requirements of these principles, for example, whether freedom of speech protects all forms of hate speech, are likely to be subject to reasonable disagreement and so must be determined by fair procedures. In the same fashion, we can understand the basic principles of Hausman's AL/D metric to be justifiable to all citizens, but recognize that the interpretation of these principles – the assignment of QALY values to limitation/distress pairs – must be left to deliberative democratic procedures.

One might grant that from the perspective of the PJR, Hausman's AL/D metric is importantly different from experienced utility and decision utility metrics where these metrics are understood to be grounded in sensory hedonist and preference satisfaction accounts of wellbeing. But, one might question whether there is any important difference between Hausman's metric and decision utility metrics where the latter are understood as democratic procedures for evaluating health states. After all, Hausman's metric, like decision utility metrics, relies heavily on a procedure to assign QALY values to health states.

In response, consider that there is an important difference between Hausman's metric, and decision utility metrics – understood here as democratic procedures. In contrast to decision utility metrics, citizens have sufficient reason to accept the basic principles of Hausman's metric regarding the evaluation of health states. This is an important difference since it means that Hausman's metric satisfies the PJR on a highly plausible interpretation of it. By contrast, decision utility metrics, understood procedurally, do not satisfy the PJR. Instead, they offer a democratic procedure for evaluating health states should public reasoning regarding the value of health states prove inconclusive. Since citizens have sufficient reason to agree that the badness of health states depends on (1) the extent to which they limit people's activity, and (2) the pathological suffering they involve, such public reasoning is not inconclusive and so there is no reason, from the standpoint of the PJR, to opt for a *purely* procedural solution such as a decision utility metric.

#### 4. HAUSMAN'S METRIC: A CLEAR ALTERNATIVE TO DECISION UTILITY METRICS?

Although I think there is a principled difference between Hausman's metric and decision utility metrics from the standpoint of the PJR, this last objection raises an important question. Given that Hausman's metric relies on a procedure to evaluate health states, to what degree is it really superior to decision utility metrics from the standpoint of the PJR, where the latter metrics are understood to offer citizens a fair democratic procedure for adjudicating their reasonable disagreements about the nature of the good life? I take this question to not only be theoretically interesting, but also, as I explain below, of interest to policymakers.

Hausman would no doubt claim that although his metric relies on a deliberative procedure to evaluate health states, there is an important difference between the procedure his metric employs, and the procedure decision utility metrics employ. Decision utility metrics assign values to health states by (1) eliciting people's personal valuations of them; and (2) aggregating these valuations. In the face of reasonable disagreement regarding the nature of wellbeing, these metrics therefore aggregate individuals' private views regarding the impact of various health states on their personal wellbeing, whatever their view of their own wellbeing happens to be. By contrast, Hausman envisions a different type of procedure for assigning QALY values to limitation/distress pairs. Rather than appeal to people's private preferences regarding these pairs, Hausman (2015: 186) suggests that QALY values be assigned through a deliberative process in which participants reason together about the value of different limitation/distress pairs. As an example of such a process, Hausman (2015: 187) suggests the use of deliberative groups such as citizen juries. As Hausman (2015: 186) puts it:

Instead of attempting to value L/D pairs in terms of personal choiceworthiness, the evaluation procedure illustrated [above] makes explicit that what is needed is a set of *public* quality weights. There is no aggregation or averaging to be done. What is at issue are public not personal values, to be determined by reasons not votes.

As this quote suggests, Hausman (2015: 179–186) offers an illustration of an evaluation procedure that he claims avoids reliance on the aggregation of individual preferences. This procedure is not intended to be the final word on this matter, but only intended to illustrate how such an evaluation might begin (Hausman 2015: 179). Most notably, Hausman (2015: 182–183) suggests that the value of different activity limitations could be determined by (1) the (adjusted) median labour incomes, and (2) the reported 'subjective experience' of those with the limitations in question. Median incomes, Hausman (2015: 182) suggests,

can be understood to offer a public valuation of different limitations. Reported subjective experience, Hausman (2015: 182–183) claims, can act as a proxy for the value of different activity limitations since people with greater limitations are likely to be more miserable.

Hausman would probably claim that his proposed evaluation procedure constitutes an important difference between his metric and decision utility metrics from the standpoint of the PJR. However, I am deeply sceptical that Hausman's proposal of tasking deliberative groups to reason together to assign QALY weights to limitation/distress pairs offers a clear alternative to the procedure employed by decision utility metrics. It is simply not clear how participants can rationally assess the disvalue of certain limitation/distress pairs except by asking how these pairs impact people's wellbeing, and it is not clear how participants can do this without employing – perhaps implicitly – particular conceptions of wellbeing. Hausman's own specific proposal for the evaluation of limitation/distress pairs illustrates this problem. Evaluating health states on the basis of median labour incomes seems, at base, no different from appealing to people's private preferences. What are labour incomes, after all, but the result of people's aggregated preferences for certain types of services? Additionally, the appeal to reported subjective experience seems to use a sensory hedonist metric to measure the disvalue of activity limitations, which seems highly questionable if the goal is to get away from evaluating health states on the basis of controversial conceptions of wellbeing.

Now, there may be a variety of different ways in which people's private views of wellbeing could be employed to evaluate limitation/distress pairs and Hausman may have reasons to favour one rather than another.<sup>16</sup> For example, Hausman might think that these pairs should be evaluated by deliberative groups, tasked with answering the question: to what extent are the particular limitation/distress pairs likely to impact the wellbeing of one's fellow citizens? Hausman might also think that certain illiberal conceptions of the good life should not be considered in the evaluation of health states for the purposes of informing government policy, and so think that there are constraints on the conceptions of wellbeing that may be appealed to.

However, if Hausman's deliberative participants can't avoid evaluating limitation/distress pairs by appeal to controversial conceptions of the good life, it seems far more democratic to employ something like a decision utility metric to assign these values. Policymakers could ask citizens *directly* to assign values to limitation/distress pairs, rather than doing so through the type of deliberative procedure Hausman has in mind which may exclude some voices or give greater weight to others.

<sup>16</sup> Thanks to an anonymous reviewer for pressing this point.



Importantly, on this proposal the decision utility metric in question would be nested within Hausman's AL/D metric. Respondents would be asked to assign QALY values to limitation/distress pairs where these pairs have already been ordered at a general level by Hausman's metric. The point would be to assign QALY values to each of the empty boxes in the above chart, with the chart imposing constraints on how respondents may assign these values: boxes to the right must receive lower QALY values than boxes to the left and boxes below must receive lower QALY values than boxes above. From here on, I shall refer to such a proposed metric as Hausman's AL/D metric\*.

Hausman's AL/D metric\*, though it contains a nested decision utility metric, is still different from a decision utility metric. Hausman's metric\* places constraints on the ways in which respondents can assign QALY values: health states that involve greater activity limitation and greater pathological suffering must be ranked worse than health states that involve lesser activity limitation and lesser pathological suffering. Of course, this only matters if some respondents possess conceptions of the good life that would lead them to rank health states differently. While it is difficult to imagine anyone possessing a conception of the good life that would lead them to rank health states with mild pathological suffering as worse than health states with moderate pathological suffering (assuming the health states in question possess the same activity limitation); it is possible to imagine someone possessing a conception of the good life that would lead them to rank a health state that involves physical limitations in instrumental activities of daily living as better than a health state that involves only minor social or occupational limits (assuming these states possess the same degree of pathological suffering). If playing the violin is my passion and vocation, I might genuinely prefer being a paraplegic to having a condition that limits the dexterity of my hands.

There is thus a genuine difference at the level of principle between Hausman's AL/D metric\* and decision utility metrics. Although both rely to some extent on people's conceptions of the good to evaluate health states, Hausman's metric\* places constraints on the extent to which these private conceptions of the good can influence health state valuations. These constraints ensure that health states are ordered in terms of the degree to which they limit people's activity and the degree of pathological suffering that they involve. Given the interpretation of the PJR that I offer above, Hausman's AL/D metric\* is still relevantly different from decision utility metrics, though not as superior as Hausman might claim.

Despite this difference at the level of principle however, it is important to recognize that Hausman's metric\* may not imply health state valuations that different from those implied by decision utility metrics. Whether it does or not will depend on contingent empirical factors. For example, if both metrics employ the same elicitation tool – e.g.

time-trade-off – and if there are very few respondents like the violinist above, both metrics should imply similar health state evaluations.

To sum up, decision utility metrics not only offer a sufficiently liberal procedure for evaluating health states should public reasoning prove inconclusive. If I am correct that Hausman's AL/D metric should incorporate a decision utility metric as a fair procedure for assigning values to limitation/distress pairs, decision utility metrics may not yield health state valuations that differ significantly from Hausman's metric so understood – i.e. Hausman's AL/D metric\*. Why might this conclusion matter?

Suppose you are a policymaker of a liberal society and you are responsible for deciding how to assign QALY values to health states. You currently use a decision utility metric to do so but after reading Hausman's *Valuing Health* you are concerned that doing so does not constitute a liberal approach to health state valuation. Suppose too that switching from your current decision utility metric to Hausman's AL/D metric is quite costly, involving re-training of your staff, carrying out new evaluations etc. and that Hausman's metric faces a number of implementation challenges. Suppose finally that you agree with my claim above that the most democratic way to complete Hausman's AL/D metric is to nest a decision utility metric within it. Given this last conclusion of my analysis, it's not clear to me that you should make the switch. Unless your society has a substantial number of people disposed to rank health states in a way that would violate the constraints of Hausman's metric, switching is unlikely to change your health state valuations significantly and so is unlikely to change how resources are allocated. Additionally, my analysis also shows that it is possible to understand decision utility metrics as adequately liberal – i.e. not best from the standpoint of the PJR, but a close second. Preferring less just policies for reasons of cost or because of implementation challenges is always dangerous, but it strikes me that it's not clear what the best decision is on balance.

## 5. CONCLUSION

Many liberals take themselves to be committed to the principle of liberal neutrality, the claim that the state should be neutral amongst conceptions of the good life. Many liberals also understand this principle to be grounded in the more basic principle that states should exercise their authority in ways that are justifiable to their citizens – the PJR. But, many liberals committed to these two principles also claim that states should take steps to protect and promote citizens' health, for example, by implementing public health measures and providing citizens with access to personal medical services. This set of commitments poses a puzzle since to set priorities amongst competing health service programmes,

policymakers need to be able to assign values to health states, and to do this, they need to determine the effect of different health states on people's wellbeing. Can policymakers calculate QALYs while complying with the principle of liberal neutrality and the PJR? Or, must they appeal to controversial conceptions of wellbeing?

In this paper, I have sought to resolve this puzzle, asking whether any of three existing health state metrics satisfy the PJR. I argued first that experienced utility and decision utility metrics do not, though I did acknowledge that decision utility metrics can be understood, from the standpoint of the PJR, to offer a fair procedure for evaluating health states. I argued second that Hausman's AL/D metric does satisfy the PJR, since it is based on principles that citizens have sufficient reason to accept. I argued finally that although Hausman's metric is superior from the standpoint of the PJR for this reason, this superiority is not as great as one might expect.

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