

**Review of Daniel M. Hausman's *Valuing health. Well-being, freedom, and suffering*. Oxford: Oxford University Press, 2015, 267 pp.**

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## INTRODUCTION

At least since the 1980s, rising health care expenditures have become a central public policy issue in industrialized countries all over the world. Since then, the debate on resource allocation in health care has been increasingly framed in terms of the economic framework of costs and benefits. Economic evaluations gained pivotal significance in public policy and keep attracting a lot of attention as an area of research today. Given this practical and theoretical relevance, critical, conceptual analyses of economic evaluations of health practices, which open up the discourse for non-economists, are indispensable. Daniel M. Hausman has provided such an analysis. He offers a painstaking investigation of generic health measures, i.e., scalar measures quantifying the overall health in a population. These measures are not only needed when it comes to the allocation of resources, but are also required for epidemiological and demographic purposes (pp. 1-6).

## HEALTH AND ITS MEASUREMENT

The book can be divided into three parts. In the first part (ch. 2-5), Hausman raises the questions what health is and how it can be measured. Following Boorse, he adopts a naturalistic definition of health in terms of the relative functional efficiency of the body's parts and processes (p. 14). While this notion of health would be tentatively measurable in terms of probabilities of survival in some specified environment, Hausman argues that this is not what those interested in health measures are actually up to (p. 31). What is relevant for constructing generic health measures is how health bears on things people care about, such as activities, relationships, and feelings. Hence, generic health measures are not measuring the amount of health as such, but rather the *value* of health (p. 42). To approach the question of what kind of value we are dealing with, Hausman asks what the preference elicitation methods currently

used are actually measuring. The most common generic health measure used in the context of allocating resources is the quality-adjusted life year (QALY). It combines information on mortality and morbidity by adjusting each life-year with a quality weight which is supposed to mirror the health related quality of life (HrQOL) in the respective health state. While the concept of HrQOL seems intelligible at first glance, a closer investigation reveals that its meaning is unclear and its relevance for generic health measures highly questionable (pp. 47-51). For one thing, there is no consensus in the literature as to how quality of life should be defined. Some authors refer to mental states, others to subjective judgments, just to mention two examples. Yet, if quality of life is taken to be a subjective measure of how good one's life is at a certain point in time, it is doubtful whether it can serve as a measure of the value of health. The reason given by Hausman consists in an argument running like a common thread through the whole book: the badness of ill health cannot be completely captured by its effect on well-being; in fact, one can have a very high subjective quality of life while being in bad health and vice versa (pp. 48, 94-95, 117-16, 144-45). Beyond that, it is also unclear how the predicate "health related" is to be understood. A motorized wheelchair, for instance, certainly has the potential of improving a person's quality of life but the question remains as to whether such external tools should be regarded "as improving HrQOL, in the same way as treatments do", or rather "as improving quality of life while leaving the health-related part unchanged?" (p. 48).

When it comes to the actual measurement of HrQOL, health economists implicitly shift to another measure. Currently, health states are valued by means of preference elicitation methods, an example being the time trade-off, which asks the respondents for the number of life years they would be willing to sacrifice in order to be cured from a certain condition. The quality weight is then calculated as the ratio of the remaining life time in the respective health state to the remaining life time in perfect health (p. 49). Apparently, the notion of HrQOL does not surface in the questions posed. As their name suggests, the preference elicitation methods used in the surveys are eliciting preferences, instead. As Hausman has convincingly demonstrated before (see Hausman 2012), the economic notion of preferences has to be understood as cognitively demanding "total subjective comparative evaluations of alternatives" (p. 75). This implies that a preference is the *outcome* of and not an input in an evaluation process, in which the individual takes into account

everything that matters to her. Hence, there is no reason to assume that preferences elicited via the time trade-off and similar methods mirror HrQOL (p. 50).

### HEALTH, WELL-BEING, AND PREFERENCES

Part two (ch. 6-12) provides an elaborate analysis of the relationship between the concepts of health, well-being, preferences, and subjective evaluations. To begin with, Hausman discusses whether health can and should be valued by its effect on well-being. According to John Broome, a central problem of this approach is that the contribution health makes to well-being cannot be separated from the contributions of other factors (p. 66-67). Although exceptions exist, the consequences of ill health for well-being crucially depend on contextual factors such as geography, technology, and social norms. Generalizing the argument, it can be said that the value of a token health state differs across persons and circumstances, so that it seems as if the value of health cannot be measured at all (p. 68). Yet, Hausman proposes two ways of averaging the values of tokens to reach values of types of health states. For one thing, the value of a kind of health state could be taken to be “an average of the values of tokens of that kind”, for another, it could be identified with the average value of tokens in a standard environment, i.e., the average “standard value” (p. 70). As Hausman shows using the example of paraplegia and its consequences in different environments, both approaches can lead to quite different results, so that “[a]pplying either the average or the standard value to calculate average population health then exaggerates how bad paraplegia is in accessible countries and understates how bad it is in inaccessible countries” (p. 72). Consequently, it is doubtful whether one scalar measure can serve international comparisons of health within epidemiological studies (p. 73).

If the average or standard value of health is regarded in terms of its impact on well-being, the question arises as to whether well-being can be measured by eliciting preferences. Although Hausman rejects the current practice of valuing health states by means of preference elicitation methods and stresses that preference satisfaction does not *constitute* well-being, he argues that under certain assumptions, preferences can function as *evidence* for well-being. In particular, it has to be the case that “in favorable circumstances (that is, when individuals have all the relevant information and are free of rational flaws) there is good reason to defer to their judgment concerning what is better or worse for them” (p. 76).

This is the assumption of evaluative competence. In addition, the person's preferences must be based on self-interest, be consistent, and founded on true beliefs (pp. 76-77). If these premises are met, preferences provide a good guide to well-being regardless of which philosophical theory of well-being was true.

Yet, this "evidential view" is questionable in different respects, as has been convincingly shown by Sarch (2015) and Hersch (2015). To give an example, Sarch (2015, 157) maintains that the claim that the evidential view holds no matter what account of well-being was actually true, is unsubstantiated. If, for instance, an objective list theory of well-being was correct, but most people formed their preferences on the basis of what they think would make them feel good, their preferences would not track what is in fact good for them. Furthermore, Hersch (2015) points out that Hausman's argument does not succeed in justifying the use of preference-based measures rather than any other measure of well-being. Yet, the most serious problem consists in the fact that the notion of "self-interest" remains unclear. If I prefer a state of affairs in which my beloved ones flourish, is this a preference based on self-interest? When it comes to evaluating health states, Hausman argues that respondents should be "instructed to state not their actual preferences but what their preferences would be if they were thinking only about their own self-interests, or, more simply, they can be asked which alternative would make them better off" (p. 77). Yet, I doubt whether the value of a health state could possibly be valued without taking the effects on and the involvement of other persons, especially dependents, into account (see Baker and Robinson 2004, 45). At any rate, the mentioned assumptions do not hold in actual health measurement surveys, since the respondents are facing an unfamiliar and intricate task and are not provided with enough information, just to mention two problems (pp. 86-87).

That being said, eliciting preferences faces a more fundamental challenge: the question of whom to ask, persons in the respective health state or the general public. The quality weights elicited from these samples differ systematically from each other to the extent that persons in a certain health state usually assign higher weights to their condition than the general public (pp. 90-95). Which group is mistaken, then? In all probability, none of them. If the differences stem from the adaption to a health state on the part of the patients, the diverging values may truly mirror their perceived quality of life.

Therefore, the systematic differences in the preferences elicited may not reflect any inaccuracy of the answers, but may actually point toward the inadequacy of defining the value of health in terms of subjective well-being. For if the severity of a disability is *defined* in terms of its impact of subjective well-being, one either has to stipulate that disabled persons cannot be as satisfied with their lives as non-disabled persons, or that they are not disabled. Yet, “that would be an erroneous way to understand disability, one that is at odds with the notion of comparative functional efficiency” (p. 95). A physical impairment, such as deafness or paraplegia, is a functional limitation, no matter what its impact on well-being. The same is true when it comes to positive mental states or happiness, as Hausman illustrates discussing a proposal by Dolan and Kahneman (pp. 104-19). Although the discussion is sophisticated and raises a number of objections, it boils down to the conclusion that health limitations matter regardless of their impact on happiness or feelings (p. 118). Hence, since the value of health is not an entirely subjective matter, delegating the evaluation of health states to the public is unwarranted (pp. 97-98): If “the task is to assign a location or number to how disabling a health state is, there is no obvious reason to ask members of the population rather than study the question directly” (p. 59).

Up to now, all considerations point to the inadequacy of valuing health by means of its impact on subjective well-being as well as to the latter’s immeasurability (pp. 120-33). However, Hausman finally points out that there are currently no better alternatives available (pp. 145-47). Adopting a concept of well-being as flourishing, consisting “in the dynamic coherent integration of objective goods into an identity”, he finally finds a way to identify truth conditions for interpersonal comparisons of well-being and to make well-being measurable to some extent (p. 141). The reason is the following:

Subjective experience is one indicator of whether someone is flourishing. To the extent that people are evaluatively competent—which is to say, to the extent that their preferences manifest a coherent identity that is rich in objective goods—(and also rational, self-interested, and well-informed), their preferences are good evidence concerning their well-being (p. 141).

Whether health states should be valued by their contribution to well-being, Hausman concludes after having examined the issue from all possible perspectives, depends on the respective values’ purpose. If “one seeks a measure of what matters about a health state to the individual

experiencing it, then, given our current capacities, there seems to be no better measure of health than the contribution the health state makes to well-being” (p. 151). Hausman dubs this measure the “private value” of health and makes some valuable suggestions as to how their elicitation can be improved (p. 151-52).

### **PUBLIC POLICY PERSPECTIVE**

In part three (ch. 13-17) Hausman considers the value of health from the vantage point of public policy and argues that it should not focus on the private but the public value of health. To put flesh on this concept, he sketches an account of the “liberal facilitator state” and its tasks. In particular, the “goal of policy in a liberal state is to expand and secure the range of worthwhile alternatives that are accessible to individuals and to protect its institutions” (p. 161). Whereas the private value of health depends on the individual’s aims, activities, and goals in life, these idiosyncrasies do not matter from the vantage point of liberal state policy (pp. 158-59). Being largely neutral toward the individuals’ specific goals, public policy should secure “the basic prerequisites for common activities and competencies, including especially, the competencies for citizenship” (p. 160). What matters about health from this perspective lies first and foremost in how far health states limit the activities citizens can engage in (p. 163). Since the liberal state also has “duties of care and compassion”, the suffering a health state entails is relevant for its public value as well. It deserves emphasis that “only specifically health-related suffering should be a target of health policy” (p. 165) whereas suffering that is not a property of a health state has no bearing on its public value. Hausman gives the example of a violinist with a tendon problem who suffers because her career is ended. Unless she develops a clinical depression, her condition “is no more serious from a public-health perspective than the same tendon problem in anyone else” (pp. 165-66). Having thus defined the concept of the public value of health as depending on two dimensions—activity limitations and pathological suffering—Hausman provides a rough draft of how to measure it (pp. 171-87). Crucially he illustrates that this valuation process is to a large extent determined by normative reasoning and assigns a much more limited role to public input than current practices do (p. 186). The public values are determined by reason, though, and not by votes, as Hausman puts it pointedly.

The last chapters of the book (ch. 15-17) focus on cost-effectiveness analysis (CEA), discuss its technical and ethical problems, point out in how far Hausman's account of public values ameliorates these issues, and make a case for a restricted use of CEA within health policy. It is commonly acknowledged by now that QALY maximization leads to unacceptable distributional consequences and that it "would be deeply morally wrong to base policy exclusively on considerations of cost-effectiveness" (p. 191). For example, when all that matters is the overall sum of QALYs, it makes no difference whether it is constituted by either small benefits to a large group of persons or huge benefits to a few. This is the so-called aggregation problem (pp. 212-13). Furthermore, QALY maximization leads to unjust discrimination against the disabled when it comes to life-saving treatments because due to their restricted potential to health, saving the disabled will never engender as many QALYs as saving a healthy person's life. In the face of these issues, the problem of resource allocation is generally couched in terms of a trade-off between fairness and efficiency. Hausman rejects this metaphor because in his opinion, except in the case of discriminating the disabled, the rejection of CEA's consequences does not stem from fairness considerations (pp. 200-01). Consider his interpretation of the aggregation problem:

[A] plausible explanation of our gut reactions traces them to our compassionate outrage at the thought that our policy might let some people die in order to cure headaches or sore throats. [...] I think that compassion and benevolence, rather than fairness, grounds the objection to rationing via cost-effectiveness (p. 213).

Given the scarcity of resources the demands of compassion cannot be met, because not everyone in need can be treated, so that the aggregation problem thus cannot be solved. Yet, compassion could be taken into account by establishing "an appeals process within a universal health-care system that permits, as exceptions, cost-ineffective treatments in cases where death or great suffering are immanent and there is reasonable prospect to benefit" (pp. 215-16). Discrimination against the disabled, by contrast, indeed poses a fairness problem which cannot be solved by modifying the value of health because the "problem lies not with the values assigned to health states, but in reliance on those values to allocate health resources" (p. 202). This circumstance has led other authors to question the normative relevance of CEA in general (see L bbecke 2015; Klonschinski forthcoming), but, for Hausman, it merely points toward the

restrictions that have to be imposed on CEA's application. These are quite extensive indeed, since health care rationing also has to take into account the values of opportunity, solidarity, and equal respect (p. 215). Hausman thus concludes that the "ethical restrictions on the use of cost-effectiveness information to allocate health-related resources are severe, and it is a mistake to expect cost-effectiveness analysis to make fine discriminations" (p. 218).

### UPSHOT

Hausman's contribution to the debate on generic health measures is a very important one. I do not know of any other book presenting such an elaborate philosophical inquiry of the topic. Serious readers need stamina and should be prepared for the book's intricate conceptual analysis. The innovative concept of public value seems very promising, not least because it solves the problems of adaption and does not rely on conceptually shaky preference surveys. I think there are some problems with the evidential view of the connection between preference satisfaction and well-being and I am less convinced than Hausman seems to be that in the face of the serious ethical challenges, CEA can play any major role in allocating resources. Here, additional research carving out the specific implications of Hausman's considerations seems necessary. That being said, I emphatically recommend the book to anyone interested in generic health measurement.

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