Social Science & Medicine 181 (2017) 158–167

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Acceptable health and priority weighting: Discussing a reference-level approach using sufficientarian reasoning

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ARTICLE INFO

Article history:
Received 6 May 2016
Received in revised form
14 March 2017
Accepted 24 March 2017
Available online 27 March 2017

Keywords:
Acceptable health
Sufficientarianism
Health care priority setting
Resource allocation
Distributive justice
Priority weights

ABSTRACT

Health care systems are challenged in allocating scarce health care resources, which are typically insufficient to fulfil all health care wants and needs. One criterion for priority setting may be the 'acceptable health' approach, which suggests that society may want to assign higher priority to health benefits in people with "unacceptable" than in people with "acceptable" health. A level of acceptable health then serves as a reference point for priority setting. Empirical research has indicated that people may be able and willing to define health states as "unacceptable" or "acceptable", but little attention has been given to the normative implications of evaluating health benefits in relation to a reference level of acceptable health. The current paper aims to address this gap by relating insights from the distributive justice literature, i.e. the sufficientarian literature, to the acceptable health approach, as we argue that these approaches are related. We specifically focus on the implications of an 'acceptability' approach for priority weighting of health benefits, derived from sufficientarian reasoning and debates, and assess the moral implications of such weighting.

1. Introduction

Scarcity in health care resources requires sensible decisions to be made about which treatments to fund publically and which not to fund. In a number of countries, cost-effectiveness analysis is used to inform such decision-making (Franken et al., 2012; Harris et al., 2001; Stevens and Milne, 2004). In such economic evaluations, health benefits of interventions are expressed in relation to their costs, thus providing information for priority setting on the basis of efficiency and maximization of health benefits within the available budget. Health benefits of interventions are usually expressed in quality-adjusted life years (QALYs), a measure that combines length and health-related quality of life in a health utility score. A quality of life score of 1 reflects perfect health and a score of 0 reflects dead. Scores below 0 reflect health states considered as being worse than dead (Drummond et al., 2005; Weinstein et al., 2009).

Recent literature (Brouwer et al., 2005; Wouters et al., 2015) has argued that economic evaluation studies commonly, albeit implicitly, take 'perfect health' as a reference point in the valuation of health gains. Such studies consider all health states below 1 as losses in health with a potential for improvement up to perfect health, and, ceteris paribus, give equal priority to equal-sized health improvements irrespective of the initial health state. However, we may wonder whether perfect health is always the most relevant reference point for the valuation of health benefits, because not all deviations from perfect health may be considered equally important for treatment.

Empirical findings, for instance, suggest that people may regard some non-perfect health states at older age as rather common and acceptable (Brouwer et al., 2005; Péntek et al., 2014; Wouters et al., 2015). In the context of limited resources, it may then be more appropriate to adopt a more modest reference level in priority setting, for example an age-dependent non-perfect but still acceptable level of health. Consequently, evaluation studies may not give all health gains of equal size equal value, and for instance may differentiate between health gains in people with unacceptable health states and in people with acceptable (although non-perfect) health states. In this line of reasoning, people with

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http://dx.doi.org/10.1016/j.socscimed.2017.03.051
0277-9536/

unacceptable health states may thus receive a higher priority for treatment than those with acceptable health states. For example, if for a specific group of people (say 80-year olds) a quality of life level of 0.7 is regarded acceptable, a higher value may be assigned to health gains in 80-year olds whose health currently is below 0.7 than to health gains in 80-year olds above that acceptable level of health.

Previous research on the 'acceptability' approach was mainly empirical in nature and suggests that people are willing and able to identify levels of acceptable health, and find health problems increasingly acceptable with rising age of patients (Brouwer et al., 2005; Péntek et al., 2014; Wouters et al., 2015). However, so far little attention has been given to the normative implications of the approach. The current paper aims to address this. We consider the premise that acceptable health could be used as a principle for health care resource allocation and investigate its consequences. We do this by relating insights from the distributive justice literature to the acceptable health approach. The sufficientarian literature is of particular interest here, because it is directly relevant for an allocation framework based on a notion of acceptable health. We specifically focus on the implications of an acceptability approach for priority weighting of health benefits, derived from sufficientarian reasoning and debates.

In the remainder of this paper, section 2 first provides brief overviews of the acceptable health and sufficientarian literature, and then discusses what the two have in common and how they differ. Then, the core of this paper, section 3, discusses the normative implications of using an acceptable health approach for health care priority setting, using insights from the sufficientarian literature. Section 4 concludes.

2. Background

2.1. Acceptable health

The notion of acceptable health is derived from the idea that some health problems may be considered to be acceptable to live with (at some stage), while others are considered to be unacceptable to live with. Hence, to some extent, non-perfect health may be a 'normal' part of life and ageing (Brouwer et al., 2005; Wouters et al., 2015). In health state valuations, this level of acceptable health serves as a reference point for priority setting with higher priority to benefits in people with unacceptable than in people with acceptable levels of health. Such an approach may incorporate distributional societal preferences in the allocation of health care resources (Brouwer et al., 2005; Wouters et al., 2015).

Acceptable health as a reference point for priority setting stands in a line of work that stresses the importance of equity weighting in the context of economic evaluation and priority setting (e.g. Bobinac et al., 2012; Cookson et al., 2009; Dolan et al., 2005; Nord et al., 1999; Nord, 2005; Nord and Johansen, 2014; Schwappach, 2002; Van de Wetering et al., 2013; van Exel et al., 2015; Wagstaff, 1991; Williams, 1988, 1997). In that context, acceptability does not concern the determination of (the size of) health benefits but relates to distributional societal preferences that go beyond usual individual measures of quality of life. Acceptability underlines that the value of health benefits depends on the necessity of treatment and relates to two well-known 'equity' principles in health care: severity of illness and fair innings.

The 'severity of illness' argument gives more priority to health benefits generated in people the worse the health state is prior to treatment (Nord et al., 1999; Nord, 2005; Nord and Johansen, 2014). Severity of illness and acceptability are both need-based criteria, but differ in how they define and measure need. Severity of illness considers need on the continuous scale of health state values, while acceptability in a strict form considers only two levels of need: 'high' for those below the acceptability level and 'low' for those above.

The 'fair innings' approach stresses that every person is entitled to some 'normal' span of health, usually expressed in life years (Williams, 1997). Fair innings aims to promote equality in lifetime health which may be achieved by prioritizing people who have not had or are not expected to have their fair share of lifetime health over people who have had or are expected to have their fair share of lifetime health. We may argue that the fair innings principle supports priority to people who have not reached or are not expected to reach a 'normal' level of lifetime health. The acceptability approach may be used to define what we consider to be a 'normal' (i.e. acceptable) level of health at different points in life throughout the lifecycle in terms of quality of life. In combination, these approaches may provide guidance for taking into account some sort of 'acceptable' amount of lifetime QALYs as fair innings.

2.2. Sufficientarianism

Sufficientarians aim to promote the well-being of the badly off in society. People are badly off when their well-being is below a pre-determined threshold of sufficiency, i.e. having enough. w Sufficientarians promote the well-being of the badly off by strictly disentangling the moral value of benefits above this threshold from those below it. The threshold level of sufficiency should represent some standard of living without suffering and distress which allows people to live a decent life. Following sufficientarian reasoning, it is morally important to have enough well-being but not necessarily to have more than that. This means that rather than taking a maximizing approach, they take a satisfying approach to well-being (Brown, 2005; Casal, 2007; Crisp, 2003; Frankfurt, 1987). Clearly, the exact meaning of 'enough' is an important aspect of making the approach practical. For priority setting, sufficientarianism implies that the value attached to improvements in well-being should in some way be related to whether people already have enough well-being to live a sufficiently decent life. In a strict form, sufficientarianism is only concerned with moving as many as possible people from below to above the threshold.

Sufficientarianism is a product of dissatisfaction with egalitarianism and prioritarianism. Egalitarianism comes in many forms, but generally speaking, egalitarians consider it to be bad if people are worse off than others through no fault of their own (Crisp, 2003; Temkin, 2003). Contrary to egalitarianism, sufficientarianism claims that it is not important that everyone has the same, but that everyone has enough. As argued by Frankfurt (1987), we should not focus on what people *have* and how that compares to what others have, but on what we actually *need*. Also standardly brought up against egalitarianism is the 'levelling-down objection' (Parfit, 1997, 2000), which suggests that pure egalitarians could 'irrationally' favour equal but lower aggregate societal levels of well-being over unequal but higher aggregate societal levels of well-being. Arguably, this may even come at the cost of truncating the well-being of the best-off in society without any benefits in return, if doing so contributes to equality (Casal, 2007; Crisp, 2003; Parfit, 1997, 2000).

Prioritarians put increasingly more value on improvements the worse off people are, provided that they are in higher need, thereby, unlike egalitarians, focussing on absolute rather than relative levels of well-being (Parfit, 1997, 2000). This suggests that benefits to the worst off should be prioritized over similar-sized benefits to the better off (Crisp, 2003; Parfit, 1997, 2000). Sufficientarianism may both be broader and narrower than the prioritarian view. Sufficientarianism, in a strict sense, focuses on the badly off and not just the worst off. Provided that the sufficiency level is above the well-