

Is the Use of QALYs as the Unit of Healthcare Justice Unfair to Disabled People?

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Abstract

The quality-adjusted life years (QALY) is a measure of health-related quality of life commonly used in healthcare priority-setting. Years of life without a disability generates more QALYs than years of life with a disability, so any method of priority-setting that takes into account the number of QALYs generated would have a reason prioritise the interests of non-disabled people. I argue that this potential unfairness arises because several methodological features of health state valuation make it so that the QALY does not adequately reflect health-related quality of life with a disability.

The Potential for Injustice

Many contemporary healthcare systems, including the United Kingdom's National Health Service (NHS), make decisions about distribution of scarce resources by determining the number of quality-adjusted life years (QALYs)

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each medical intervention would produce per monetary unit. Various forms of health state valuation are used to determine how many QALYs a year of life in a given health state generates. According to current methods of health state valuation, a year of a disabled person's life produces fewer QALYs than a year of a non-disabled person's life. Hence, in cases where a life-saving or life-extending treatment can be given to either a disabled person or a non-disabled person and the treatment would be equally effective in both, a policy that calls for maximising QALYs demands that we give to the treatment to the non-disabled person—a consequence that some philosophers have argued is unjust.

John Harris has argued that it is unfair to favour non-disabled people over disabled people in the allocation of life-saving or life-extending treatments. In what Harris calls the 'double jeopardy' objection,¹ he asserts that it is unfair for a person who is already disadvantaged (by being disabled) to be singled out for further disadvantage (by being less likely to receive life-saving or life-extending treatment) because of that first disadvantage. I will argue that the double jeopardy objection fails gives a full explanation of why it is unfair to commit double jeopardy in the case of disability, and that even if the double jeopardy objection goes through, its scope will be quite limited. Instead, I will turn my attention to a separate set of concerns about the use of QALYs as the unit of healthcare justice— that existing health state valuation procedures fail to produce weights that reflect lived quality of life with a disability.

The double jeopardy objection can be interpreted in two ways: We might take it to be arguing (1) that policymakers have a *prima facie* duty not to exacerbate existing disadvantages, or (2) that disability is not in itself a relevant criteria for resource allocation decisions, and so it would be unjust to take it into account. With regard to the first interpretation, it seems plausible that we have ethical reasons to avoid causing further disadvantage to people who are already disadvantaged. But we are not obligated, all things considered, to avoid committing double jeopardy in every case. Even in healthcare, we can find instances where committing double jeopardy seems justified. For exam-

¹ Harris, 'QALYfying the value of life.'

ple, if a cancer patient needs a organ transplant, the fact that she has received a terminal diagnosis (a disadvantage) does, in many cases mean, that she will be moved down on the transplant list (a second disadvantage). It seems at least plausible that it is just to favour patients who do not have terminal diagnoses over those who do in allocating scarce resources. If this is so, then, it is sometimes just to use one disadvantage as a criteria with which to distribute another disadvantage.

In order to explain why it is unfair to commit double jeopardy in the case of terminal illness but not in the case of disability, we must turn to the second interpretation of the double jeopardy objection— that it is unfair to distribute disadvantage on the basis of disability because disability (unlike terminal illness) should not be a relevant factor in healthcare resource allocation decisions. There are relevant differences between the case of terminal cancer and the cases of disability with which we are concerned. While the terminal cancer patient will die soon with or without the treatment, the disabled patient is predicted to live roughly as long as non-disabled people typically do. The condition of a terminal patient may also reduce the effectiveness of the treatment, while this would not be the case for many disabilities. Thus, if it is these aspects of terminal cancer that make it relevant in healthcare allocation decisions, then disability is not in it of itself relevant.

Yet, those who favour the use of QALYs to distribute healthcare resources would assert that disability is a relevant factor (in addition to lifespan, effectiveness of treatment, and so on) because the goal of healthcare is to maximise quality of life and disabled people experience, on average, a lower quality of life than non-disabled people.² After all, in contexts where a healthcare system can choose to distribute resources towards treating a disability or not doing so, and in contexts where a healthcare system can choose between a treatment that restores the patient to full health or leaves her in a disabled health state, disability is a relevant factor. It seems that the the burden of proof lies with proponents of the double jeopardy objection to explain why

² For example: Singer et al., ‘Double jeopardy and the use of QALYs in health care allocation.’

disability should be relevant in the aforementioned contexts, but not in the context of life-saving or life-extending treatments. The question of whether or not disability is relevant in this context is precisely what is at stake when we ask if it is unfair to use QALYs as the unit of healthcare justice, and the double jeopardy objection does not get us any closer to answering that question.

Even if the double jeopardy objection goes through, it would not threaten the use of QALYs as the unit of healthcare justice because not all forms of priority setting that uses the QALY commit double jeopardy. Utilitarian forms of priority setting (called cost-effectiveness analysis, or CEA) are concerned solely with maximising the number of QALYs added. In contrast, prioritarian alternatives, like the one proposed by Trygve Ottersen,³ also give special concern to the worst off by apply equity weights to gains to the worse off. The question of who counts as the worse off differs from account to account, but it is very likely to include the disabled and chronically ill. For example, Ottersen's account proposes giving priority to the interests of those will enjoy the fewest QALYs over the course of their lifetime, a group that will certainly include most disabled people.⁴ Equity weighting can eliminate or mitigate the effects of double jeopardy, depending on the magnitude of the weights used. Even if CEA is vulnerable to the double jeopardy objection, prioritarian forms of priority setting may not be.

I think the use of QALYs as the unit of healthcare justice face a more pressing concern—the possibility that the QALY is an inadequate measure of quality of life with a disability. It systematically undervalues disabled health states, by (1) conflating individual preferences and social preferences, (2) by directing participants to adopt a perspective that does not reflect their typical outlook, and (3) by failing to exclude social factors that disadvantage disabled people. Because my objection targets the QALY itself, it applies not just to CEA, but also to prioritarian approaches, as well as any other system of healthcare resource allocation that uses the QALY.

³ Ottersen, 'Lifetime QALY prioritarianism in priority setting.'

⁴ *Ibid.*

For simplicity, I will limit my discussion to a single method of health state valuation: the time trade-off method (TTO). Moreover, in my references to disability, I will assume that the disability in question (1) does not affect the person's longevity, (2) does not hinder the effectiveness of the treatment, and (3) does not render the person's life no longer worth living. While I realise that not all cases of disability match these assumptions, I will exclude these considerations in order to examine whether disability in it of itself should make a difference in the allocation of healthcare resources.

I. Individual and Social Preferences

Measures of well-being can be subjective (e.g. a good life is one where one's preferences are satisfied) or objective (e.g. a good life is one that has certain features, though they need not be the same features for everyone).⁵ In order for a measure of wellbeing to be useful in resource allocation, it must embody features of both subjective and objective measures. A subjective measure of well-being will be good at reflecting what people want for themselves (individual preferences) and will maintain neutrality on questions of what constitutes wellbeing, but it will not successfully reflect what people want for others (social preferences). When it comes to deciding how resources are allocated in a publicly funded healthcare system like NHS, social preferences should play an important role. For example, even some individuals very much want cosmetic surgery for themselves, it still seems justifiable for cosmetic surgery to not be covered by a public healthcare system if the public at large does not believe it is the responsibility of the government to fund this service. Conversely, an objective measure of well-being accounts for importance to the public, but it risks being insufficiently neutral. For example, an objective theory might consider it important for children on the autism spectrum undergo therapy that ensures they behave in as neurotypical a way as possible, even though the children themselves and their families do not view the condition as a dysfunction that must be ameliorated.

⁵ Parfit, 'What makes someone's life go best.'

The QALY attempts to find a middle ground, by averaging individual preferences. However, I argue that this approach is seriously flawed because, in doing so, many health state valuation procedures use data about individual preferences to draw inferences about social preferences. For example, the time trade-off method (TTO) asks participants to imagine that they are in a given disabled health state d , and to decide how many years off the end of their life they would give to be in full health instead of in health state d . Their responses are used to determine how many QALYs a year in health state d generates (between 0 and 1, with 0 being death and 1 being full health). So if participants would, on average, give up half their remaining lifespan to live without disability d , then d is valued at 0.5 and generates 0.5 QALY per year of life. The more years participants are willing to give up to be rid of D , the fewer QALYs a year in health state d generates. Though the weight given to d was calculated using data about individual preferences, that same weight is used to make decisions about healthcare resource allocation that should reflect social preferences.

The TTO asks participants to make ‘intrapersonal trade-offs,’ where one can gain a benefit (in this case, being non-disabled) at the cost of giving up some other benefit (years off the end of one’s life). In contrast, problems of resource allocation in healthcare are cases of ‘interpersonal trade-offs’ where we can provide a benefit to one group at the cost of failing to provide a benefit to a second group. The TTO conflates individual preferences with social preferences by attempting to use data about individuals’ willingness to make an intrapersonal trade-off to draw inferences about their willingness to accept interpersonal trade-offs. But, as Frances Kamm points out, the willingness of individuals to make an intrapersonal trade-off is no indication of their willingness to make the corresponding interpersonal trade-off.⁶ Consider the following set of cases:

Years Imagine that if by giving up years off the end of your life, you could become ten times wealthier than you currently are. How many years

⁶ Kamm, *Bioethical Prescriptions* 424-6.

would you give? Would you give any?

Life-saving treatment You can give a life-saving treatment to either Tonya or Maria. They are equivalent in all respects except that Tonya is ten times as wealthy as Maria. To whom would you give the treatment?

I would think that, in response to **Years**, many people would be willing to give up at least a few years to gain an attribute they genuinely value, be it wealth, intelligence, or something else. In contrast, I would suspect that few would respond that we should favour Tonya's interests over Maria's in **Life-saving treatment**. We can prefer being wealthy to not being wealthy, without preferring wealthy people over middle-class people. This is a case where we are willing to make an intrapersonal trade-off, but where we are not willing to make the corresponding interpersonal trade-off. Yet, the time trade-off method asks questions of the type in **Years** to draw conclusions about what we should do in situations like **Life-saving treatment**. When we replace gains in health with gains in wealth, intelligence, or some other valued attribute, we can recognise that in doing so, the TTO problematically conflates individual preferences with social preferences. In the same way that we may give a positive number in **Years** but refuse to favour Tonya in **Life-saving treatment**, we might be willing to give up years of our life to be rid of a certain disability on the TTO without being willing to favour the interests of people who do not have that disability over the interests of people who do.

Empirical evidence supports the idea that social preferences differ in significant ways from individual preferences. Studies demonstrate when individuals are asked directly about how healthcare's resources should be distributed, their responses diverge from conclusions drawn from responses to health state valuation procedures.⁷ For example, the public tends to favour giving greater shares of resources to help those who are more severely ill, even when those resources would help them less (that is, produce fewer added QALYs) than they would help those who are less severely ill.⁸

⁷ Reviewed in Menzel, 'Allocation of Scarce Resources.'

⁸ Nord, 'Health politicians do not wish to maximise health benefits.'

Kamm explains this phenomenon by pointing out that the moral relevance of a given benefit depends on the context. For example, if we could either give a flu vaccine to one person or give the vaccine to another person and cure her headache in the process, it seems the additional benefit of alleviating a headache is significant enough to motivate us to give the vaccine to the second person. At the same time, if we can save one person's life or save another person's life and cure her headache in the process, it seems that we can be reasonably ambivalent about who to save. In the context of receiving a flu vaccine, the added benefit of curing a headache is morally relevant, but in the context of receiving a life-saving treatment, that same benefit is no longer morally relevant. Kamm suggests that in the same way, the added benefit of being non-disabled may be morally relevant in the context of the TTO, where only years at the end of one's life are at stake, but morally irrelevant in the context of receiving a life-saving treatment. Kamm calls this the Principle of Irrelevant Goods.⁹

This argument provides what the double jeopardy objection lacks— an explanation as to why disability is not relevant in the context of life-saving and life-extending treatments. In such contexts, disability is irrelevant because the benefit that each patient stands to receive is so great that it swamps the benefit of being non-disabled. A disabled person might want badly enough to be in full health that she is prepared to give up some years off the end of her life in order to do so, but still value her life just as much as a non-disabled person values theirs— just as a middle class person might give up many years of their lives to be wealthy, but still value her life just as much as very wealthy people value theirs. Indeed, empirical evidence demonstrates that disabled people— even those with very severe disabilities— tend to report that they are very or somewhat satisfied with their lives.¹⁰ As Kamm emphasises, the idea that 'if one can have only x, one cares about it as much as one

⁹ Kamm, *Bioethical Prescriptions* 424. Kamm has complicated her view on this issue in more recent work, but I will not discuss her work in very much detail here.

¹⁰ Louis Harris and Associates, *The ICD Survey of Disabled Americans*; Albrecht and Devlieger, 'The disability paradox.'

would care about y if one had it' does not mean that 'one cares to have x as much as one cares to have y.'¹¹ If this so, then even if disabled participants report that they would give up a significant number of years to be non-disabled on the TTO, the resulting value should not be used to draw inferences about how life-saving or life-extending resources should be allocated.

This argument is corroborated by empirical findings that suggest that though participants are willing to make intrapersonal trade-offs when it comes to disability, the public is averse to making interpersonal trade-offs that favour non-disabled people over disabled people. A study in Norway found that participants were unwilling to favour non-disabled people over paraplegic people in distributing a life-saving or life-extending treatment.¹² Participants may be particularly averse to making interpersonal trade-offs when it comes to disability because they recognise that being disabled is a socially salient trait and are sensitive to the danger of discriminating against disabled and chronically ill people.

The time trade-off method conflates individual preferences and social preferences by attempting to use data about people's willingness to make intrapersonal trade-offs to draw inferences about their willingness to make interpersonal trade-offs. This ignores the potential that a benefit might be very important in one context but irrelevant in another. We have good reason to believe that the benefit of being non-disabled, like the benefit of being wealthy, is one of these cases: That most people are willing to sacrifice years of their life to be non-disabled is not necessarily an indication that we as a society are or should be willing to prioritise the lives of non-disabled people over the lives of disabled people.

¹¹ Kamm, 'Deciding Whom to Help' 235.

¹² Nord, 'The relevance of health state after treatment in prioritising between different patients.'

II. Perspectives and Interval Scales

The discrepancy in our intuitions between **Ten years** and **Life-saving treatment** can be explained in another way as well. In **Life-saving treatment**, we are aware that both people in the thought experiment need treatment and will die if they do not receive it. The immediate prospect of death may affect our evaluation of the case. The spectre of death in **Life-saving treatment** makes extravagant wealth seem much less important than it did in **Years**. In this section, I argue that our perspective affects our valuation of various health states, and that the time trade-off method imposes an artificial perspective that does not reflect the way disabled people ordinarily view their health states.

Suppose that Aiko is in full health and believes that quadriplegia is only slightly better than death. She claims that if she became quadriplegic tomorrow, she would prefer to be euthanised because being a quadriplegic is preferable to death by such a marginal degree that continuing to live as a quadriplegic person would not merit the cost, effort, burden to family, etc of doing so. Yet, if Aiko had a terminal illness and was offered a treatment that would save her life but leave her quadriplegic, she may be very happy to accept the treatment. That is, her view of quadriplegia in face of imminent death may differ significantly from her view of quadriplegia when she is in full health. In other words, Aiko's perspective affects her evaluation of various health states. Her evaluation of quadriplegia from the perspective of full health (1.0) is dramatically different than her evaluation of quadriplegia from the perspective of imminent death (0). The story I have told about Aiko is an intuitive one—the world is rife with anecdotes about how one's appreciation of some thing changed dramatically once it was in immediate danger of being taken away.

The value of any given health state is supposed to fall on an interval scale—the difference between 0.1 and 0.2 is meant to be equivalent to the difference between 0.9 and 1.0. Yet, in practice, the perspective from which we think about various health states affects the way we perceive these intervals. The difference between health states that are closer to our perspective

are exaggerated while the difference between health states that are further away from us seem smaller. That is, from the perspective of someone at a health state of 1.0 or close to it, the difference between quadriplegia and death may seem small, but from the perspective of someone at a health state of 0, the difference between death and quadriplegia seems very significant indeed.

Note that our perspective does not necessarily have to be the health state we actually occupy.¹³ People with an acute illness will maintain the perspective of full health, because they are aware that their reduced state of health is not permanent. For example, if Aiko is typically in full health, then having even a very bad case of pneumonia for a week is unlikely to change her perspective about the badness of quadriplegia in the way having a terminal illness might. Conversely, when Aiko is terminally ill, she considers quadriplegia from the perspective of death, because she is imagining a future where is either dead or quadriplegic.

I argue that TTO undervalues disabled health states by asking participants to take a perspective they do not usually occupy. Though the TTO method ostensibly asks participants to occupy the position of someone with the disability in question, it also presents full health as an open possibility. With some exceptions (e.g. deaf people eligible for cochlear implants), full health, or anything close to it, is not an open possibility for disabled or chronically ill people and if that option became available, their valuation of their own health state would likely change. Empirical research commonly finds that the array of choices available changes the extent to which a person is satisfied with their own situation.¹⁴ In the same way, it is plausible that a person's valuation of a health state depends on what options are available.¹⁵ For example,

¹³ In this way, this phenomenon is not the same as adaptation. Adaptation requires a change in perspective through being at a reduced health state for some significant period of time, but it is necessarily (though helpful) to be at a given health state at all in order to take that perspective.

¹⁴ Schwartz, *The Paradox of Choice*.

¹⁵ This line of argument is akin to Kamm's Sufficiently Good Only Option (SGOO) argument, which argues that when an option is sufficiently good and is the only

a deaf person may view her current situation much less positively once she realises that she is in fact eligible for a cochlear implant, just as Maria might feel much less satisfied with her life once she became aware that her college classmate, Tonya, is now extremely wealthy.

It is a hotly contested question whether health state valuation should utilise people with the disability being investigated or those without it. I believe that the problem I have raised about perspective applies irrespective of whether or not the participants have the disability in question. Regardless of whether or not the participants have the disability, they are asked to envision a world in which that disability is curable— and that is not the perspective from which disabled people typically regard their lives. Because TTO asks participants to make valuations about disabled health states when full health is an option, it asks participants to step into a perspective that most disabled people do not typically occupy. And since our evaluations of health states depends heavily on our perspective, this may mean that TTO produces distorted valuations of disabled health states that do not reflect the lived experience of disabled people.

III. Social Disadvantage

Finally, I argue that health state valuation, whether through TTO or any other method, is almost certain to confound the social ill effects of disability with its health-related ill effects.

QALYs are supposed to be measures of health-related quality of life— and only health-related quality of life.¹⁶ So long as people are in the same

available option, people will want it just as much as they want a better option. However, while the SGOO argument is concerned with the question of whether disabled people value their lives as much as non-disabled people value theirs, my argument points to a more general problem about how health state valuation procedures may misrepresent disabled people's lived quality of life. My argument may apply even if the disability in question does not allow for a sufficiently good quality of life or even if it is not the only available option (if other options are not easily accessible).

¹⁶ Bognar and Hirose, 'The value of health.'

health state, years of their lives are to generate the same number of QALYs, even if social factors like wealth, race, or gender may have a dramatic effect on the quality of their life. QALYs are not meant to take these social factors into account. There are good reasons for this. QALYs are supposed to pick out the health states that require medical treatment—that is, that require changes be made to the person with that health state. In cases of social injustice, we think that changes should be made to the social conditions that create the injustice, not to the person who suffers it. In fact, it would seem perverse, for example, to suggest that black Americans use plastic surgery to become white or that women in patriarchal societies undergo gender reassignment in order avoid injustice. When black people and women face injustice, the problem is not with their being black or women, but with the social conditions that make their lives worse because of it. It is these social conditions that must be ameliorated and a focus on the individuals rather than the society distracts from the real nature of the problem.

To some extent, the same is true of disability. Insofar as the badness of a disability is the result of social conditions, those ill-effects should not be taken into account by valuations of health-related quality of life. Though disability is different than class, race, or gender in that it typically involves a reduction in health-related quality of life, it also involves the social disadvantages that make the lives of disabled people worse than they otherwise would be. Here, I borrow the distinction between impairment and disability from the social model of disability, where *impairment* refers to the health state that marks one out as disabled, and *disability* refers to the social conditions that makes worse the experience of having that health state.¹⁷ For example, a person diagnosed with clinical depression is impaired by the sense of low self worth and suicidal ideation she experiences, but she is disabled by the social isolation she faces because of stigma against people with mental health problems. The Office for Disability Issues report that almost a third of disabled people reported difficulties in accessing goods and services.¹⁸ In the case of

¹⁷ Morris, 'Impairment and Disability.'

¹⁸ Office for Disability Issues and Department for Work and Pensions, *Disability facts*

certain disabilities, like autism or deafness, the social disadvantage may be most or even all of what make the condition bad. For some autistic people or deaf people, the goal is not to be in full health, but to live in a world where the social disadvantages of being autistic or deaf are ameliorated. There is little doubt that in the case of almost every disability, there are ways in which a change social conditions could dramatically improve the lives of people with that disability, even if the severity of their impairment remains exactly the same. Taking these considerations into account in health state valuation is problematic not just because it abandons the aim for the QALY to be a measure of health-related quality of life, but also because it obscures the impetus to change the social conditions that make disabled people's lives worse than they have to be.

This is not a problem for valuations of acute health conditions. Though the same social facts that make life unnecessarily difficult for people who experience fatigue because of a chronic condition would also make life unnecessarily difficult for someone who experiences fatigue as a symptom of pneumonia, people who have pneumonia are not disadvantaged in the way that disabled people are. One's having pneumonia does not come define them in any significant way in the way that one having a chronic illness does. Disabled people face social disadvantage precisely because their conditions persist for long enough or because the nature of their condition is such that it becomes an inextricable part of the way others see them and the way they seem themselves.

I have argued that the social disadvantages faced by disabled people should not be taken into account in health state valuation. Yet, qualitative studies indicate that participants often take into account the social factors that affect the experience of living with a disability. For example, some participants in Baker and Robinson (2003) were concerned that in their disabled state, they would be a burden or a source of emotional anguish to their families or that there would be no one to care for them.¹⁹ These are not factors that neces-

and figures.

¹⁹ Baker and Robinson, 'Response to standard gambles.'

sarily come along with having a disability. If social care were more readily available and/or if being a carer or having a disability were not so stigmatised, these participants may have felt differently.

More subtly, participants were extremely concerned about their prospects for independence²⁰— what they would be able to do for themselves and what they would need others to help with. The answers suggested that the participants felt their lives would be of lesser value if they were made dependent on other people because of their disability, and that to be dependent on others was to be a ‘burden’ to them or to ‘impose’ on them. Such considerations might be viewed as a reflection of ableist attitudes in society. Though all people require help from others to survive— most of us need help from farmers to provide us with food, for example— only the forms of help that disabled people require are stigmatised.²¹ We might imagine that in a perfectly just world, care would not only be available for those who require it, but that people would not feel badly about requiring it.

It is not surprising that participants in health state valuation would take into account social disadvantage. The social factors that disadvantage disabled people are so deeply entrenched in our mental picture of what it means to have that disability that it may be difficult for people to imagine what life with a disability would be like if these conditions were entirely rectified. Even if participants were explicitly asked to disregard the social factors that disadvantage people with disabilities, it may be very difficult or impossible for them to do so. These social factors may act as a confound that causes these procedures to undervalue disabled health states.

A Divergence in Goals

I have argued that the time trade-off method may underestimate the quality of life experienced by disabled people because it (1) conflates individual and social preferences, (2) imposes an artificial perspective that may not reflect

²⁰ Ibid.

²¹ Silvers, ‘Reconciling Equality to Difference.’

the way disabled people typically regard their lives, and (3) and allows participants to take into account social factors, which confound valuations of health-related quality of life.

Taken together, I believe these issues give us reason to believe that procedures like the time trade-off method systematically undervalue disabled health states. Undervaluing disabled health states is problematic not just because it introduces inaccuracy into the process of healthcare priority-setting, but because they do so in a way that systematically disadvantages some of the worst off. Many governments accept that they have a particular duty to protect the interests of several groups that have been historically disadvantaged, including disabled people. For example, in the UK, the Equality Act 2010 places a legal duty on policymakers to consider how each new policy will impact these protected groups.²² Worse, it is not clear how the time trade-off method and other methods of health state valuation can be improved to avoid these flaws: Offering the possibility of being non-disabled is a necessary part of the TTO, and it will always be difficult to untangle the medical and social factors that are responsible for the disutility of having a disability.

I think these issues should lead us to seriously consider the possibility that chronic and disabled health states should be evaluated in a categorically different way than acute health states. As Anita Silvers points out,²³ with acute conditions, the goal of healthcare is to cure or ameliorate the condition to the fullest extent possible. Methods of health state valuation like the TTO reflect this goal. But disabled and chronically ill people, many of whom cannot be cured or do not want to be cured, do not share this goal: ‘Their good is not the common good, for the common good is to be cured, and that is a good from which, in virtue of their chronic condition, they are definitely removed.’²⁴ For many disabled people, the improvement in the quality and length of their lives (quantified as the number of QALYs) is not the only or even primary goal of healthcare. For them, healthcare is a constant presence in their lives,

²² Equality Act 2010

²³ Silvers, ‘Judgment and Justice.’

²⁴ Silvers, ‘Judgment and Justice’ 369.

and good healthcare, ideally, would be just one of a set of complex factors enables them to have the fullest, most productive lives possible. For example, less intrusive healthcare options may be preferable for disabled people, even if they generate fewer added QALYs. Further discussion is merited about whether priority-setting should or can be revised to better reflect the role that healthcare plays in the lives of disabled people.

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