

# 'OVERLAPPING CONSENSUS' ON DEATHS EARLY IN LIFE

Hilary Greaves (Oxford)

Oslo workshop on 'Saving lives from the badness of death'

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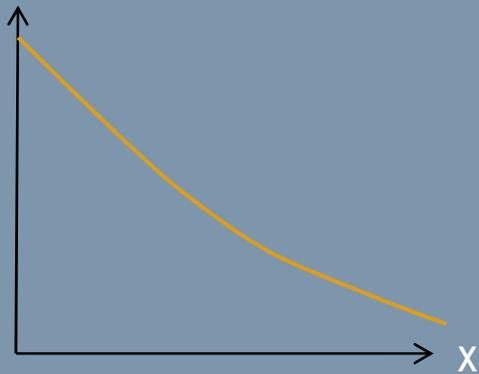
# OUTLINE

1. The badness of deaths as a function of age: theory and intuition
2. The importance of consensus in healthcare prioritisation
3. No hope of consensus? A brief survey of population axiology
4. Multiple accounts of the intuitive badness-of-death function from rival population axiologies
5. A different kind of consensus
6. A more revisionary approach; quasi-consensus via moral uncertainty

# THE DISVALUE OF DEATH AS A FUNCTION OF AGE AT DEATH

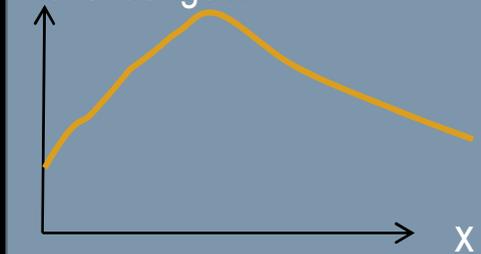
- Question: How does the 'badness of a death' (for the purpose of healthcare prioritisation) vary as a function of age?

'Theoretical'  
badness of death  
at age  $x$



- Theoretical account: The badness of a death is an *increasing function* of the number of years of life lost.
- Intuitive account: the worst deaths are those around ages 15-30; *earlier* deaths, as well as later deaths, are less bad.

'Intuitive' badness of  
death at age  $x$



# TWO 'DALY' FRAMEWORKS

- Original framework ("standard DALYs"): the badness of a death is just the number of resulting Years of Life Lost (YLLs).
  - But: Cut off at the point of birth. (Stillbirths are not 'bad' at all.)
  - Problems:
    - Implausible discontinuity at time of birth
    - Clash with brute intuitions
- Modified framework (Jamison et al 2006):
  - Badness of a death at age  $x$  = YLLs *multiplied by*  $f(x)$ , where  $f(x)=0$  at sufficiently young ages (-9 months?), increasing to 1 at sufficiently old ages (15? 30?).
  - This model can match the intuitive 'badness-of-death graph'.
  - But: Nothing said (yet) about how to *justify* the weighting function  $f(x)$ . (The 'acquisition of life-potential'??)

# GROUNDING THE MODIFIED-DALY FRAMEWORK: A TIME-RELATIVE INTERESTS ACCOUNT?

- The time-relative-interests rationalisation of the intuitive ‘badness curve’:
  - A “victim-focussed account”: The degree to which a given death is bad for the purposes of CBA just is the degree to which it is bad *for* the person who dies.
  - The degree to which the loss of a given future life-year is bad *for* the person who loses it, in turn, is a function of
    - The quality of life that would be experienced in that life-year, *and*
    - The degree to which the (actual) person would have been *psychologically connected* to the life-year in question.
  - f(x) is the average degree to which a person, as she is at age x (i.e., at the time of her death), would have been psychologically connected to her later life-years, had those later life-years not been lost.

# THE IMPORTANCE OF CONSENSUS IN HEALTHCARE PRIORITISATION

- In one sense, the ‘best’ resource prioritisation framework is just whatever the *correct* ethical theory says it is.
- But when large sums of *public* money are at stake, there are also political considerations: the framework must be broadly *acceptable according* to the ethical views of those who fund it/those affected by it. (If only because otherwise the masses might revolt.)

“A soldier for the one true conception of the good (that he or she believed in) would march to battle for the [‘burden of disease’] indicator founded on his or her maximalist system of beliefs. The advantages of such soldiering are clear: internal consistency, intellectual elegance... The disadvantages, however, are great. The resulting measure of health may well be unappealing to those who disagree with the starting maximalist position. If the purpose of studying the burden of disease is to enhance debate over the appropriate objects of health policy and to create a common mode of communication... the maximalist approach may well be self-defeating.” (Murray 1996)

# MOGENSEN'S ARGUMENT: TRI FAVOURED BY THE NEED FOR CONSENSUS?

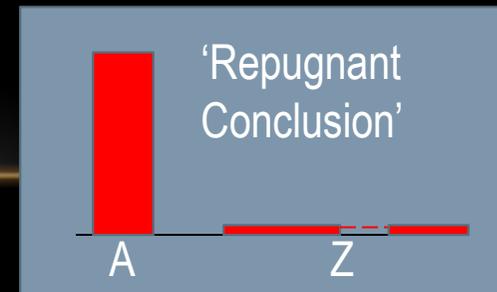
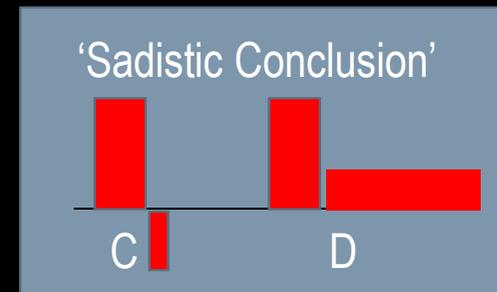
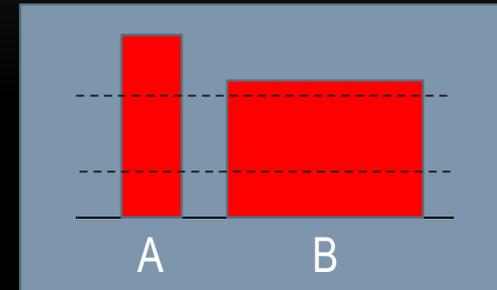
- Mogensen's suggestion:
  - Alternatively (to the TRI account), one could pursue e.g. a 'human capital' or 'replaceability' approach to justifying the intuitive badness-of-death curve
  - But the TRI explanation is a better way to ground the modified framework for 'consensus'-type reasons:
    - "That we should prioritise the prevention of greater misfortunes is clearly a respectable moral principle, and one with which few would disagree. The designers of the DALY metric have repeatedly stressed that the metric cannot rest lightly upon deeply controversial moral ideals, but must reflect shared values... The moral principles implicit in [the alternative accounts], even if correct, are likely to generate significant controversy, and are thus dispreferable". (Mogensen (ms))

# NO HOPE OF CONSENSUS

- A complete account of how to do CBA for these issues must make *comparative betterness* judgments of states of affairs in which a person dies at any given age vs a state of affairs in which that person was never conceived in the first place.
  - (Talk of 'badness' can be unhelpful...)
- These *are variable-population* matters. Therefore, we are into the domain of population axiology.
- But there is a notorious lack of consensus in this domain...

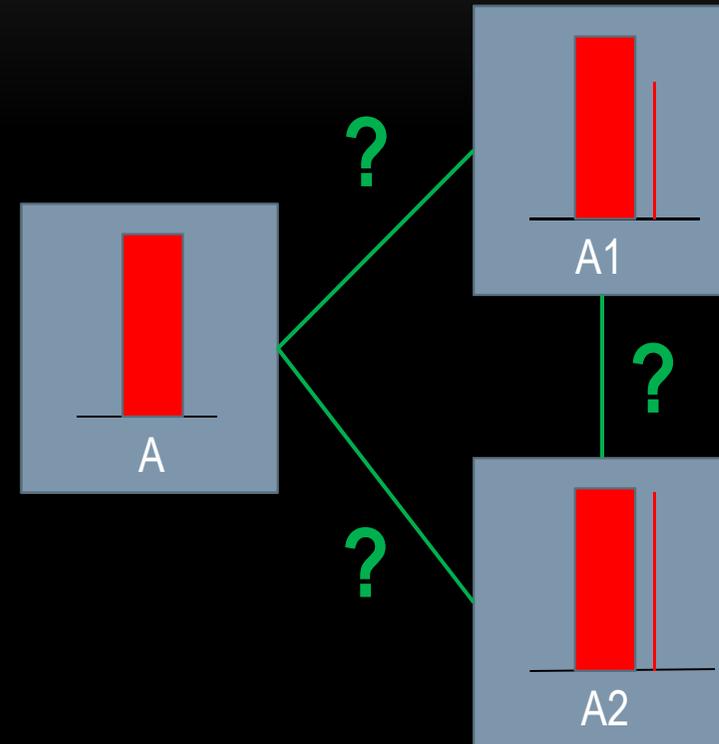
# POPULATION AXIOLOGY: A VERY SHORT SURVEY

- Q: what is the right ranking of states of affairs in terms of overall goodness, when those states of affairs (may) differ over the number of people who (ever) live?
- Average utilitarianism: the overall goodness of a state of affairs is the *average* lifetime well-being level of all those who ever live
  - Implies the 'Sadistic Conclusion' ( $C > D$ )
- Total utilitarianism: the overall goodness of a state of affairs is the *total* lifetime well-being level of all those who ever live
  - Implies the 'Repugnant Conclusion' ( $Z > A$ )
- Critical level utilitarianism: the overall goodness of a state of affairs is the total amount by which people's lifetime well-being levels exceed some (presumably positive) 'critical level'
  - Implies the Sadistic Conclusion *and* a version of the Repugnant Conclusion



# POPULATION AXIOLOGY (CONT'D)

- Person-affecting views...
  - Basic 'neutrality' idea: adding an extra person is 'neutral'. But what exactly does this mean?
  - The 'principle of equal existence': adding an extra person (other things equal) always leads to a state of affairs that is *equally as good as* the status quo
    - Self-contradictory ( $A \sim A1$ ,  $A \sim A2$ , but  $A1 < A2$ )
- Impossibility theorems



# FIRST WAY: PERSON-AFFECTING APPROACHES

- Person-affecting way:
  - 'Person-affecting principle': a death is bad only if, and insofar as, it is bad *for* some person.
  - A nonconception is not 'bad' at all, because *there is* (as things turned out) no person for it to be bad for.
    - (*Put aside, for now, the worry about whether this 'neutrality' makes sense*)
  - To avoid the discontinuity: postulate that personhood is a matter of degree:
    - A foetus is a person only to a very small (or zero) degree
    - An adult is fully a person
    - There is a smooth transition in between.
  - Suggests interpreting Jamison et al's 'f(x)' as degree of personhood at time of death.
  - (Alternatively: appeal to TRI *in place of* degrees of personhood.)

## SECOND WAY: A CRITICAL-LEVEL APPROACH

- Simple theory: death at age  $x$  is better than nonconception by an amount

$$\sum_{x'=0}^x w(x') - \alpha,$$

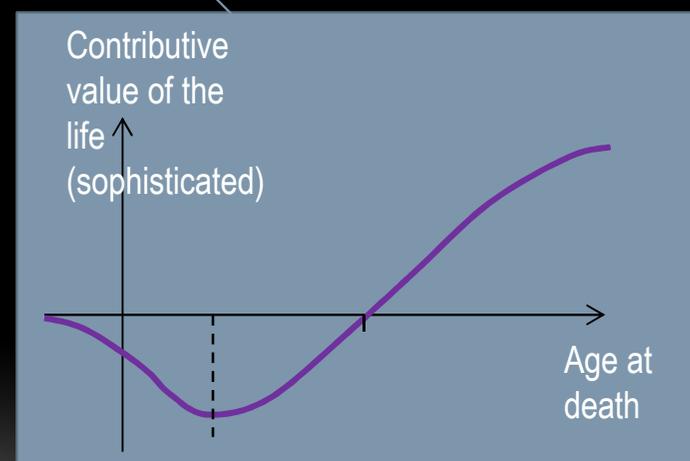
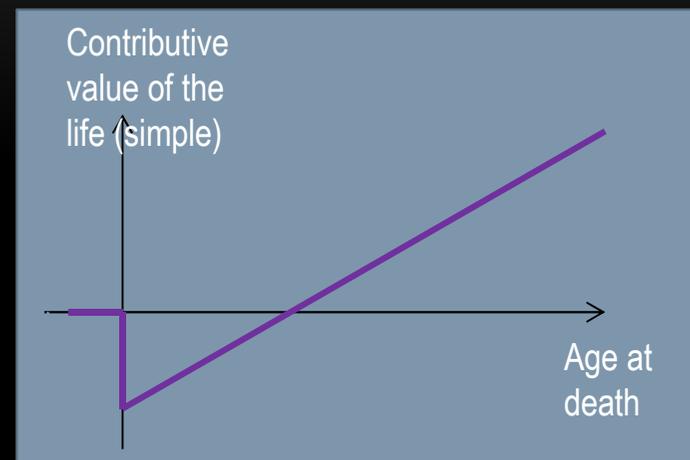
where  $\alpha$  is the critical level, and  $w(x')$  is the person's (momentary) well-being at when she is aged  $x'$ .

- To avoid discontinuity, modify to

$$\sum_{x'=0}^x w(x') - \alpha^*(x),$$

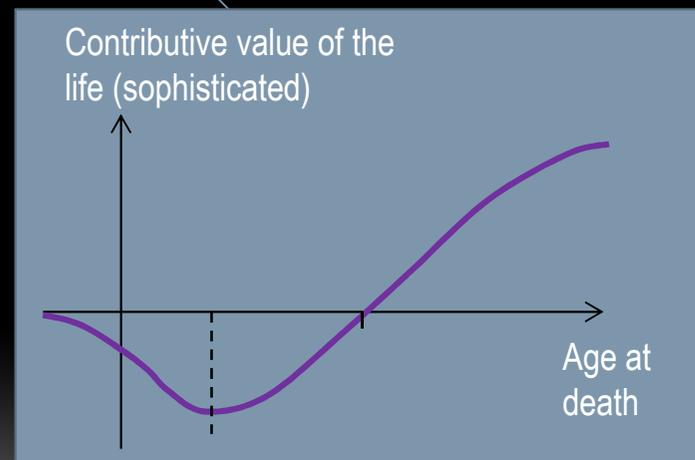
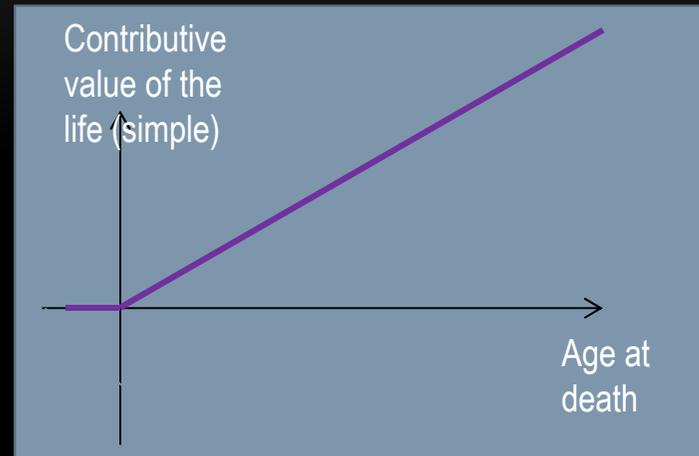
where  $\alpha^*(-9 \text{ months})=0$ ,  $\alpha^*(30 \text{ years})=\alpha$ .

- On this theory,
  - There is some age (40? 100?) such that an average life ending at that age is equally as good as the life's never having existed
  - There is some lower age (15?) such that an average life being lived up to, but then ending at, that age is the worst case.



# THIRD WAY: A 'TOTAL' APPROACH

- Simple theory: Death at age  $x$  better than nonconception by an amount  $\sum_{x'=0}^x w(x')$
- Counterintuitive consequence: 'the more births the better'.
- But if we also take into account the effects of the life in question on *other* people (as we should...), we might get a different story.
  - It's plausible that the early years of life do have negative *net* contributive value ('children are expensive and don't work').
  - If so, then it could well be that the worst scenario is for someone to die at age 15.
    - Callous? (But survey respondents do cite factors like 'lost investment'.)



# TWO KINDS OF CONSENSUS

- Agreement on fundamentals:
  - We agree on *a particular set of ethical principles that imply* the given prioritisation formula. (E.g., those involved in the TRI account?)
- Agreement at the effective level:
  - We agree on *the prioritisation formula to be used*, but not necessarily on the *reasons why* that is the appropriate formula.
- Seeking agreement *on fundamentals*, in the present case, is hopeless. But (maybe?) we *do* have agreement at the effective level. And (if so) this is enough.

“Despite the fact that there are opposing comprehensive conceptions affirmed in society, there is no difficulty as to how an overlapping consensus may exist. Since different premises may lead to the same conclusions, we simply suppose that the essential elements of the political conception [of justice, i.e., the things on which Rawls hopes for a broad consensus], its principles, standard and ideals, are theorems, as it were, at which the comprehensive doctrines in question intersect or converge.” (Rawls, “The idea of an overlapping consensus”, p. 9; my emphasis)

# THE LIMITS OF CONSENSUS

- It's not clear that *the most independently plausible versions of the four frameworks* canvassed above will really all generate the same results. (As opposed to: one can see how, within each framework, one *might* recover the intuitive result.)
- The moves required to get some frameworks (esp: the total-utilitarian one) to agree with the intuitive badness-of-death curves might have differential revisionary implications elsewhere in healthcare prioritisation.
- Relatedly: It's not clear that we should slavishly follow, rather than revising, folk intuitions on the present question. (Cf e.g. discounting.)
  - Why do we actually have these intuitions, anyway? (Grief at the death of a relative? Grief at one's own death? Third-party sense of tragedy?) The answer might be a debunking one.
- An alternative approach: 'Moral uncertainty'

# SUMMARY

- Folk intuitions support a (particular) nonmonotonic form for the badness of death. But the rationale for those intuitions is not immediately clear.
- These are tricky issues: we are up to our necks in ‘population axiology’.
- Insofar as we seek to build a framework on ‘consensus’, we should seek to defend the claim that otherwise diverse ethical foundations agree that these intuitions are correct at an ‘effective’ or ‘emergent’ level, rather than the (hopeless) claim that some *particular* foundation is uncontroversial.
- Even that (less *obviously* hopeless) claim may be false, though.
- Alternative: modest revisionism, combined with a moral-uncertainty approach to the rival foundational theories.
  - ‘What would the result be?’ This is a hard question.

# REFERENCES

- Jamison, Shahid-Salles, Jamison, Lawn and Zupan (2006), “Incorporating deaths near the time of birth into the global burden of disease”
- Mogensen (ms), “Justifying and modelling acquisition of life-potential for  $DALYs_{SB}(R,K,A)$  using the time-relative interest account”
- Murray (1996), “Rethinking DALYs”
- Rawls (1987), “The idea of an overlapping consensus”

# A MORE REVISIONARY APPROACH

- Suppose it is the case that:
  - Properly worked out, the various candidate 'fundamental moral theories' issue *differing* verdicts on the way in which the badness of death varies with age.
  - We are 'collectively uncertain' about which fundamental moral theory is the best.

What then should our 'political' framework (for practical prioritisation) look like?
- Observation: This is (at least from the collective point of view) a problem of moral uncertainty.
  - One approach: Do whatever our *collectively-favourite* fundamental moral theory says.
  - A probably more promising alternative: *Maximise expected moral value*.
    - This is just the analog of the way we routinely treat *empirical* uncertainty (viz. expected utility theory).
    - In the present case, it amounts to taking a weighted average of the badness-of-death curves given by rival theories. (The result may or may not be roughly the 'naïve' one.)

# MURRAY ON OVERLAPPING CONSENSUS...

- “An intellectually satisfying and academically secure approach to developing a measure of the burden of disease would be to start with a given conception of ‘goodness’ and proceed to develop an indicator. A welfarist might choose to design an indicator of burden based on assigning a value to each health event according to its contribution to welfare loss. An advocate of human rights might believe that the right to life has lexicographic dominance over a right to a better quality of life and propose the crude death rate as the best measure of burden. Perhaps, someone inspired by Rawls would argue for a measure that emphasizes the health conditions of those who have the worst health. A soldier for the one true conception of the good (that he or she believed in) would march to battle for the [‘burden of disease’] indicator founded on his or her maximalist system of beliefs.
- “The advantages of such soldiering are clear: internal consistency, intellectual elegance and the appeal of the proselytizing missionary. The disadvantages, however, are great. The resulting measure of health may well be unappealing to those who disagree with the starting maximalist position. If the purpose of studying the burden of disease is to enhance debate over the appropriate objects of health policy and to create a common mode of communication about the magnitude of different health problems and the costs versus benefits of alternative efforts to improve health, the maximalist approach may well be self-defeating. It was not and is not my intention to argue through the design of DALYs for any particular conception of the good life. Rather, I have sought an approach which a large proportion of society might accept as reasonable even if it cannot wholly endorse it.”