Characterising Needs in Health Care Priority Setting

Erik Gustavsson

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Erik Gustavsson

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*To Frank Gerwer for convincing me not to
drop the basic course in philosophy many years ago.*

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*Erik Gustavsson
Svärtinge Hills 2017*

ABSTRACT

The focus of this thesis is needs in the context of health care priority setting. The notion of needs has a strong standing in health care policy; however, how the idea should be understood more specifically and how it should guide decisions about priority setting remain contentious issues. The aim of this thesis is to explore how needs should be characterised in health care priority setting. This matter is approached by, first, exploring and developing the conceptual structure of health care needs, and second, discussing and suggesting solutions to normative questions that arise when needs are characterised as a distributive principle.

In the first article, the conceptual structure of needs in general and health care needs in particular is explored, and it is argued that a specific characterisation of health care needs is required.

In the second article, the notion of health care needs is explored in relation to preferences for health care within the context of shared decision-making. The paper further discusses a number of queries that arise in the intersection between what the patient needs and what the patient wants.

The third article discusses how a principle of need should handle questions about interpersonal aggregation. The paper characterises a principle of need which strikes a reasonable balance between giving priority to the worst off and the distribution of benefits with regard to interpersonal aggregation.

The fourth article discusses how a principle of need should account for the fact that patients often are badly off due to several conditions rather than one single condition. It is argued that how badly off patients are should be understood as a function of how badly off these patients are when all of their conditions (for which they need health care) are considered.

The frame story provides the terminological, theoretical, contextual, and methodological background for the discussion undertaken in this thesis. The conclusions of the articles are brought together and the discussion extended in the concluding discussion by sketching a number of conditions of adequacy for the concept and principle of need relevant for health care priority setting.

SVENSK SAMMANFATTNING

Den här avhandlingen fokuserar på behov och behovsprinciper inom hälso- och sjukvården. Behov har länge haft en stark ställning inom hälso- och sjukvården men det är omdiskuterat hur begreppet ska förstås mer specifikt och framförallt hur det ska vara vägledande för prioriteringar inom hälso- och sjukvården. Syftet med den här avhandlingen är att karakterisera behov för sådana prioriteringar. Avhandlingen tar sig an detta syfte utifrån två ansatser. För det första, genom att undersöka och utveckla den begreppsliga strukturen hos vårdbehov och, för det andra, genom att diskutera samt ge förslag på lösningar på ett antal normativa frågor som uppstår när vårdbehov skall karakteriseras som en fördelningsprincip.

I den första artikeln undersöks begreppen behov och vårdbehov utifrån den allmänfilosofiska diskussionen om behov. I artikeln karakteriseras begreppet vårdbehov på ett sätt som gör det lämpligt för prioriteringar inom hälso- och sjukvården.

I den andra artikeln utforskas begreppet vårdbehov i relation till önskemål om vård inom ramen för delat beslutsfattande. I artikeln diskuteras också ett antal frågeställningar som aktualiseras i relation till den spänning som kan uppstå mellan patientens behov å ena sidan och patientens önskemål å andra sidan.

I den tredje artikeln behandlas frågan om hur en behovsprincip bör hantera frågor som rör sammanvägning av olika personers behov. I artikeln karakteriseras och försvaras en behovsprincip som balanserar prioritet till de sämst ställda och hur hälsovinster bör fördelas.

I den fjärde artikeln förs en diskussion om hur en behovsprincip bör göra reda för det faktum att patienter ofta lider av samsjuklighet snarare än av ett enskilt tillstånd. I artikeln drivs tesen att hur dåligt ställt en patient har det bör förstås som en funktion av hur dåligt ställt patienten har det när alla patientens tillstånd (för vilka patienten behöver vård) har tagits i beaktande, snarare än hur dåligt ställt patienten har det med avseende på det specifika tillstånd för vilket patienten skall behandlas.

I kappan ges den terminologiska, kontextuella, teoretiska och metodologiska bakgrunden för diskussionen i avhandlingen. I en avslutande diskussion förs slutsatserna från artiklarna samman och diskussionen utvidgas genom att skissera ett antal adekvansvillkor för begreppet vårdbehov och behovsprinciper i vården.

LIST OF ARTICLES

These four articles constitute the basis for this thesis. In the following I shall refer to them by their Roman number.

- I. Gustavsson, Erik. (2014) From Needs to Health Care Needs. *Health Care Analysis* 22(1): 22-35.
- II. Gustavsson, Erik. & Sandman, Lars. (2015) Health-care Needs and Shared Decision-making in Priority-setting. *Medicine, Health Care and Philosophy* 18(1): 13-22.
- III. Gustavsson, Erik. & Juth, Niklas. (2017) Principles of Needs and the Aggregation Thesis. *Health Care Analysis* doi: 10.1007/s10728-017-0346-6.
- IV. Gustavsson, Erik. (2017) Patients with Multiple Needs for Health Care and Priority to the Worse off. *Under review*.

INTRODUCTION

To distribute resources according to need has been accorded a particular prominence in the health care context in many Western countries. For example, the British National Health Service (NHS) famously stated the importance of needs when it was founded in 1948, and still asserts this in 2017: “Access to NHS services is based on clinical need, not an individual’s ability to pay” (The NHS Constitution 2017, p. 3). A further example may be the Swedish Health Care Act (1982: 763, 2 §) where it is stated that “[p]riority for health and medical care shall be given to the person whose need of care is greatest.” The importance ascribed to needs in the health care sector is also stated in official guidelines from several other countries and regions (see e.g. Danish Council of Ethics 1996; Gustavsson & Wiss 2013; Hoffman 2013a; Lindsay & Reidar 2008; Melin 2007; Official Norwegian Reports 2014. See also Elmersjö & Helgesson 2008).

The scarcity of resources implies that all citizens covered by a health care system cannot have all treatments from which they may benefit. Therefore, some kind of limit setting is inescapable and it is of great importance to carefully consider the basis on which these scarce health care resources are distributed. To collect data on the efficiency of health care treatments is part of the answer. However, irrespective of the number and robustness of such studies, their results cannot answer the normative question of how scarce health care resources *should* be distributed.

Even though needs are constantly referred to in the public debate as well as in official guidelines for health care priority setting, it is not clear how this idea should be understood, and more specifically, how it should constitute a basis for priority setting. This thesis explores how needs should be characterised in health care priority setting. It focuses on the conceptual structure of needs in general and health care needs in particular, as well as needs as a distributive principle regarding how scarce health care resources should be distributed.

BACKGROUND

Needs are ascribed a special importance in the health care sector. However, it seems difficult to make sense of needs more specifically in health care priority setting (see e.g. Cookson & Dolan 2000; Culyer 1995; 1998; Mårtensson *et al.* 2006). The aim of this thesis is to do just that.

In this chapter I sketch the background for this project. The chapter is structured as follows. First, I shall outline some preliminaries for the discussion in this thesis. Second, I sketch the context for which the discussion in this thesis is relevant, with a special focus on the Swedish ethical platform for health care priority setting (henceforth priority setting). Third, I shall provide a background of the previous discussion in the general philosophical discussion about needs, and then move on to the discussion about health care needs that has been more prevalent in the field of medical ethics. Fourth, as it turns out, needs for priority setting cannot be plausibly characterised merely against this previous discussion. Therefore, I also introduce a number of related ideas from the field of distributive justice as well from the philosophy of health and well-being, which are useful in order to characterise needs in priority setting.

Preliminaries

Given that a health care system cannot do everything for everyone at the same time, health care is prioritised in one way or another. Decisions about how to allocate resources have to be made and these decisions are made whether a health care system has an informed discussion about priority setting or not. The underlying assumption of priority setting is that it is better to set these priorities explicitly and to consider the grounds on which these decisions are made than for such decisions to be made on just any basis, such as decision-makers' self-interest or prejudices.

To prioritise is to give preference to one thing rather than another. Priority setting in health care is often referred to as giving preference to one prioritisation object in favour of another such object. The prioritisation object may be conditions, treatments, patients (or groups of patients) or condition-treatment pairs, i.e. a combination of a condition and a treatment intended to meet that condition (see Broqvist *et al.* 2011. See also Liss

2004, esp. pp. 10-24). In the following, the term “priority setting” does not refer only to the ranking of such prioritisation objects; I shall employ the term in a somewhat broader sense also referring to *distribution* of health care resources. For example, this includes when governmental bodies, such as the National Institute for Health and Care Excellence (NICE) in the UK or the Dental and Pharmaceutical Benefits Agency (TLV) in Sweden, decide whether a treatment should be publically funded or not.

Rationing is a concept that is closely related to priority setting. The relevant features of rationing are well captured by Norheim (1999, p. 1426) as “...the withholding of potentially beneficial health care through financial or organisational features of the healthcare system...”. The withholding of health care may take different forms. For example, it may be done by postponing treatment, excluding treatment from the health care service or satisfying a need only to a certain degree (when it could have been optimally satisfied).¹ Note that rationing is not equivalent to the withholding of treatment for just any reason. For example, many health care systems withhold euthanasia from patients. However, their reason for doing so is, normally, neither financial nor organisational but rather because of the ethical or legal issues it raises.

How are the notions of priority setting and rationing related? I shall refer to priority setting as any distribution of resources within a health care system that could have been done differently, and rationing as the withholding of (potentially beneficial) health care. I shall assume that rationing is based on and preceded by an implicit or explicit process of priority setting, and henceforth will employ ‘priority setting’ as the key term in this thesis.

The notion of priority setting should be further distinguished from efficiency improvements. Suppose there is a fixed budget, which allows for treating both Jack and Jill. If efficiency is increased, both would still be treated but such that their treatments demanded less resources, meaning that, say, Jim could also be treated. Hence, even though efficiency improvements may result in a different distribution, the increase of efficiency does not involve ranking or withholding, which is the focus of interest here.

Although it may be difficult to know exactly who decides what in complex health care systems, it seems clear that some priority setting decisions are taken on an

¹ These three kinds of rationing are sometimes referred to as done by delay, denial or dilution (see Tinghög 2011, pp. 21-22. See also Klein *et al.* 1996).

individual level while other such decisions are taken on a group level. This thesis discusses problems that arise on both these levels. On the individual level, there may be questions arising when professionals involve patients in decisions about their care, whereas on the group level questions arise when a governmental body, such as, again, NICE or TLV, decide whether a treatment should be funded or not.

In principle, I believe that most health care interventions may be distributed according to need. However, things are not that simple. For example, it may seem difficult for health care professionals to know how needy a patient is before a first examination. Therefore, it may be better to give patients access to such first examinations on some other basis, such as what the examining professional judges to be the most appropriate measure based on an assessment of the surmised health problem.² In the following, I shall therefore, for reasons of simplicity, focus on the need for treatment and will side step the discussion of whether a patient can need diagnostic measures or not.

Furthermore, I shall assume that the following discussion takes place in a publically funded health care system of which Sweden, Norway, and the UK are standard examples. I focus on publically funded systems as these are the ones in which the notion of need has a central role (at least following official guidelines). In order to sketch the context for which this thesis is relevant I shall, in the following, provide the example of the ethical platform for priority setting in Sweden.

The Swedish Ethical Platform for Priority Setting

The following section should be read as an outline of a context in which the questions discussed in this thesis arise and have practical importance.

In 1995, the Swedish government finalised an investigation on priority setting in health care (Ministry of Health and Social Affairs 1995a; 1995b).³ The commission suggested that priority setting should be guided by an ethical platform, which was

² This does not necessarily mean that people should have the right to any diagnostic measure. Moreover, it does not seem reasonable to say that *no* diagnostic measures could be plausibly distributed according to need as, for example, there may be a second step in the diagnostic measuring procedure which can be based on need. However, these complexities will not be further discussed here.

³ Note that (1995a) refers to the Swedish official document with legal status and (1995b) refers to the English translation of (1995a) (which lacks legal status).

fortified (with some minor revisions) by the parliament in 1997 (Ministry of Health and Social Affairs 1996),⁴ consisting of three ethical principles: (i) the principle of human dignity, (ii) the principle of need and solidarity, and (iii) the cost-effectiveness principle. The principles are lexically ordered, which means that the principle of human dignity should be considered before taking the principle of need and solidarity into account, and the same relation should hold between the principle of need and solidarity and the cost-effectiveness principle.⁵

(i) *The principle of human dignity.* All people have equal value and equal rights irrespective of their personal characteristics and function in society. Personal characteristics such as chronological age, gender, ethnicity, previous lifestyle and societal function should not be taken into account in decisions about priority setting.

(ii) *The principle of need and solidarity.* Resources ought to be directed to patients or activities where needs are considered to be greatest. This principle also prescribes a striving towards levelling out differences in the population regarding opportunity and outcome with regard to health. The component of solidarity is connected to a special concern for people who are not aware of their human dignity or people who have difficulty communicating their needs for health care. However, this does *not* mean that these groups should be assigned a higher priority than other groups.

(iii) *The cost-effectiveness principle.* In the government bill there are passages supporting at least the following two interpretations of the principle of cost-effectiveness:

(a) Once a patient's need has been assessed it is only if there are several treatments available with similar effects that the principle of cost-effectiveness comes into play, and implies that the one with the best cost-effectiveness should be chosen.

(b) Decision-makers should pursue a reasonable relation between costs and effects when deciding how to allocate resources between different activities, measured in terms of improved health and increased quality of life. However, the cost-effectiveness principle should not be used in such a way that seriously ill or dying people are denied

⁴ For further discussion of the Swedish system see also Arvidsson (2013); Omar (2011); Sandman (2015); The Swedish National Center for Priority Setting in Health Care (2007); Tinghög (2011).

⁵ In characterising these three principles I draw on passages from the Ministry of Health and Social Affairs (1995a; 1995b; 1996).

care (see Ministry of Health and Social Affairs 1995b, esp. pp. 106-108; 1996, esp. sec. 5.2).

Let me now make a number of brief explicatory comments on the way in which these principles are characterised (I postpone comments on the principle of need and solidarity as these comments will be revealed as the discussion unfolds). In practice the principle of human dignity has been interpreted as a formal principle of justice according to which like cases ought to be treated alike. When operationalised, such principles are often specified in terms of a list of factors that should be considered as morally irrelevant for priority setting.⁶ The reference to “all people” having equal value may be confusing. One reading would be “all people within Swedish borders” as this is where Swedish jurisdiction is at work. However, more recent legislation suggests that this is not the intention of the legislator as paperless refugees and asylum seekers are not entitled to full health care but to what in official guidelines is referred to as “care that cannot be deferred” (see Ministry of Health and Social Affairs 2012), a notion which has the purpose of demarcating a part of health care which these groups are not entitled to (see Sandman *et al.* 2014). Hence, even though universally stated, the principle of human dignity is probably better interpreted as applying to Swedish citizens.

The role of the principle of cost-effectiveness has been subjected to discussion (see e.g. Andersson 2016; Engström 2015a; 2015b; Hermerén *et al.* 2016; Sandman *et al.* 2015; 2016a; 2016b). This discussion concerns on the one hand how to understand the principle of cost-effectiveness as such, and on the other hand how to understand the lexical ordering of the principles. However, the discussion is somewhat confused. Whereas some people discuss the question of how the platform should be interpreted on normative and pragmatic grounds other people constantly refer to what interpretations are correct from a legal perspective. The project undertaken in this thesis should *not* be understood as a project of interpreting the law on jurisdictional grounds. The following discussion should be understood as a conceptual and normative one about how needs in priority setting should be characterised.⁷

⁶ It is often claimed that the principle of human dignity only guides decisions in the sense that it specifies grounds on which one should *not* set priorities. However, things are not that simple. I return to this question in the chapter on further questions.

⁷ Thus, when I, for example, comment below on passages from the Ministry of Health and Social Affairs (1996) about patients’ preferences I do not make any claims about legal interpretations. I use such

The commission also spends a few pages on discussing alternative principles that were considered but rejected as plausible principles for priority setting. For the present project it is especially interesting to mention the principle of demand, which was considered as a possible fourth principle but which was, in the end, stated as a mere recommendation that demand should be taken into account after the other three principles had been considered. To give weight to preferences as a ground for priority setting was, however, explicitly rejected by the government bill: “As the commission, we believe that while one cannot completely ignore demand and the person’s preferences these cannot constitute the basis for priority setting” (My trans. Ministry of Health and Social Affairs 1996).

It is interesting to compare such passages about priority setting with other values and practices within a health care system. As regards the role of patient preferences it is closely related to the ideal of patient centred care,⁸ in particular shared decision-making, which has been an influential trend in many health care systems over the last few decades (see e.g. Da Silva 2012). A defining characteristic for shared decision-making is that patients’ values and preferences *should* be taken into account when decisions are made about their care. The room which a model of shared decision-making leaves for patients’ preferences depends on what specific model one adopts (Sandman & Munthe 2009). Opening the door for patients’ preferences to influence the clinical judgement may result in an outcome that differs from the best evidence-based course of action. Thus, to practice shared decision-making may bring out tensions between needs and wants, and accordingly, between need-based distribution of health care and patient-centred care. The example of patient-centred care and shared decision-making on the one hand, and need-based priority setting on the other illustrates well how needs alone are not to guide priority setting but are to be integrated into complex organisations.

passages in order to show that different values and practices may come into conflict as outcomes of these jurisdictions.

⁸ An ideal towards which much health care policy seems to aspire. As regards Swedish legislation, the Ministry of health and social affairs (2013) is probably the best example of this movement (see also Gustavsson *et al.* 2015; Mead & Bower 2000).

Needs

The notion of needs is notoriously complex. Let me therefore begin this section by specifying the philosophical tradition on which I shall draw in this thesis. This will also allow me to sketch the relevant theoretical background for characterising needs in priority setting.

First, it is important to distinguish the project undertaken in this thesis from some of the efforts made in the field of psychology. An influential such example is Maslow (1968) who discussed needs in terms of drives and as a crucial part of psychological theory. He employed the term “needs” in order to signify an organism’s struggle to keep itself in balance. This notion of need signifies some sort of drive in the organism for some object and (at some point) it entails some motivation to attain this object, for example, the runner’s need for water or the alcoholic’s need for alcohol. In this tradition the notion of need is employed in order to *explain* human behaviour or motivation.⁹ This is not the focus of interest for this thesis. A notion of need relevant for priority setting should say something about how people *ought* to act or what policies *ought* to guide policies for priority setting.

Second, the current project should be further distinguished from the project undertaken by some need theorists who understand the notion of well-being in terms of need satisfaction. In the discussion about well-being, ideas about needs are usually employed in order to construct some version of an “objective list theory” about well-being. According to such a theory, the fulfilment of some specific needs are constituents of a person’s well-being (see e.g. Griffin 1986, pp. 40-55; Sumner 1996, pp. 53-60). The focus of this thesis is not to explore needs as a substantial theory about well-being but to understand needs as a basis for priority setting.¹⁰

Third, one may undertake an analysis of needs with different purposes. Some writers have approached needs as constituents of moral theory with a focus on interaction between individuals (see e.g. Miller 2012). In the context of priority setting such an

⁹ To say that such a theory of need is a theory of human motivation seems rather uncontroversial (see e.g. Liss 1993, pp. 56-57; Thomson 1987, pp. 14-15). See Sheaff (1996) for an attempt to construe a theory of health care need in terms of drives.

¹⁰ Even though a need-based objective list theory about well-being is one candidate for determining morally relevant needs for priority setting.

approach would restrict the realm of needs to handle moral issues on a clinical level. In order to construct a comprehensive theory of need relevant for priority setting, needs should be constructed as being applicable on a group level as well, as this is where many important decisions are made.

Fourth, it has been suggested that needs should, to some extent, be understood in relation to available resources (e.g. Acheson 1978; Culyer 1995; 1998). However, while the scarcity of resources implies that priorities cannot reasonably be set independent of costs it seems counterintuitive to say that to what extent a person *needs* a treatment is dependent of the cost of that treatment (see also Hasman *et al.* 2006, p. 147).

Finally, in this thesis, I shall use needs as a three-place predicate, which involves a relation between someone (a subject) *X* who needs something (an object) *Y* in order to achieve something else (a goal) *Z*. That needs relevant for moral philosophy take this formal structure is fairly uncontroversial (see Crisp 2002; Daniels 1995; Frankfurt 1984; Griffin 1986; Hope *et al.* 2010; Juth 2015; Liss 1993; 1996; 2003; McLeod 2011; 2014; Miller 2012; Ohlsson 1995; Reader 2005; Reader & Brock 2004; Thomson 1987; 2005; Wiggins 1987; 1998 [1985]; 2005; von Wright 1982).¹¹ However, even though writers may agree on this formal structure they may disagree about several substantial questions, as we shall see in the following.

In order to situate the following discussion in this general philosophical discussion about needs I shall now outline a number of crucial contributions to the discussion about needs and their potential role in moral theory. The purpose undertaken by these theorists is not to *explain* human behaviour but to investigate the moral implications needs may have for how people *ought to* act.¹² Thus, an important project for these need theorists is to analyse what needs are carrying moral weight. To undertake this project is crucial for the underlying purpose of constructing a moral theory based on needs. For example,

¹¹ For somewhat different views see Miller (1976, p. 128); Anscombe (1958, p. 7).

¹² This means, for instance, that I shall leave aside work that primarily concerns ontological questions about needs such as McLeod (2011; 2014). For readers who are familiar with McLeod's work it is worth noting a terminological difference. When McLeod refers to needs being instrumental he refers to needs being dependent on the state of mind of the person who is in need. When I argue that all needs are instrumental (as I do in paper I) I do not intend to say that all goals of all needs are mind-dependent. I claim that since needs take a three-place structure (constituted by a subject, an object and a goal) they are always instrumental or constructive to some goal or purpose. McLeod refers to this thesis as needs being essentially "purposive".

how should the difference between the need for a bottle of vodka in order to get drunk and the need for surgery in order to survive be accounted for?

In order to denote the difference between morally important needs and morally non-important needs it is common to distinguish between instrumental needs and categorical needs (or basic, fundamental, dispositional, absolute), where the latter are conceptually dependent on a specific goal (or set of goals). Different theorists have worked out different accounts about what constitute these morally important goals, but they seem to agree that categorical needs are objective in the sense that these needs are concerned with things that are good for people, irrespective of these people's own assessments. One common suggestion is the avoidance of harm (see e.g. Thomson 1987; 2005; Wiggins 1998 [1985]; 2005; von Wright 1982) another suggestion is necessities for a minimally acceptable life (see Ohlsson 1995). Whereas these two approaches seem to be two ways to make a similar point, a further strategy is to attempt to establish a conceptual link between needs and agency (see e.g. Brock 1998; Miller 2012).

The goal component may be further analysed in various ways. The following two respects are particularly interesting for the present project. First, the question about how needs are related to the duration of good. For example, Kamm (1993; 2002) consider needs to be tied to how badly one's life *as a whole* will have gone if one does not get what one needs. Accordingly, Kamm takes need-based claims to be concerned with how well a person's life goes as a whole. However, this view is stated rather than argued for by Kamm. It is somewhat unclear why one should accept this view, especially for needs relevant for priority setting. It seems as if need-based claims may also be tied to other ideas about the duration of the relevant good, such as the view that it is the distribution of a good at specific times that matters morally (the time-slice view) or how one's life will go in prospective terms.¹³ The discussion in this thesis is compatible with any of these approaches to the duration of goods.

Second, as mentioned above, several analyses of needs characterise the goal component as objective. But is this the right way to characterise needs in priority setting? At a deeper level, it is yet another challenge for need theorists to explain how needs are related to volitional attitudes such as desires, wants, and preferences (see e.g.

¹³ For a discussion about the lifetime view and the time-slice view see for example Hirose (2015a, esp. pp. 136-146). See also McKerlie (1989; 2002).

Frankfurt 1984; Griffin 1986; Thomson 1987; Wiggins 1998 [1985]).¹⁴ It may be easy to accept that one may need what one does not want, and want what one does not need, but how this relation should be understood more specifically is less clear. To want something is to have a positive attitude towards that something, whereas a need seems to be, in some sense, independent of one's attitude. Accordingly, the tension discussed in the previous section, between patient-centred care and shared decision-making on the one hand, and need-based priority setting on the other, seems to go into even deeper theoretical questions.

In this section, I have narrowed down the focus of this thesis to needs that carry moral weight. In the following section, its focus will be further specified by moving on from needs to health care needs.

Health Care Needs

Norman Daniels, Per-Erik Liss, and the Notion of Health

One may suggest that there is a straightforward answer to how the goal component should be understood with regard to health care needs. It should be understood as health. Consider two such views: Daniels (1995) and Liss (1993), who agree on the formal structure of needs. Both take needs to be constituted by a subject for whom some object is necessary for achieving some goal. They further agree that the goal component should be understood as health; however, they disagree on how the notion of health should be understood.

Daniels understands health in a bio-statistical sense, drawing on the work by Christopher Boorse (see e.g. Boorse 1977).¹⁵ According to the bio-statistical theory, health is understood in terms of normal functioning of the human body. A person is healthy when all of that person's bodily functions make their statistically normal contribution to the person's survival and reproduction. Whenever this is not the case the person has a disease. In this sense the bio-statistical theory understands health in terms

¹⁴ I shall use desires, preferences, and wants interchangeably in order to denote what a person wants. For a discussion about how these volitional attitudes are related see for example Schroeder (2009).

¹⁵ The bio-statistical theory is critically discussed by for example Nordenfelt (1995, esp. pp. 23-34).

of absence of disease. Boorse's theory takes health to be a purely descriptive (i.e. value free) notion.

In contrast to Daniels, Liss understands health in a holistic sense, drawing on the work by Lennart Nordenfelt (see e.g. Nordenfelt 1995).¹⁶ According to the holistic theory a person is healthy if the person has the ability to achieve his or her most important goals in life. However, these so-called "vital goals" need not be the goals which one actually has but are the goals that are necessary and jointly sufficient for one's minimal happiness. Accordingly, while one's actual preferences and one's vital goals may often go together, this is not necessarily so. It follows that an external observer, such as a physician or a friend, may know better what a person's vital goals are than the person does. In contrast to the bio-statistical account, the holistic account takes health to be an essentially evaluative concept in the sense that it is necessarily desirable for its bearer.¹⁷

Roger Crisp and the Notion of Well-Being

Consider next the view put forward by Crisp (2002). He argues that if a need for health care is supposed to carry moral weight, its goal component should be understood as a theory of well-being. Thus, for a need to carry moral weight it must rest on the advancement of well-being and therefore the notion of treatment according to need must be supplemented with an account of well-being.¹⁸ A somewhat standard way to distinguish between theories of well-being (also employed by Crisp 2002) is between three kinds of theories: hedonistic theories, desire-fulfilment theories, and objective list theories (see Parfit 1984, pp. 493-502. See also Brülde 1998; Crisp 2008; Feldman 2004, 2010; Sumner 1996).¹⁹

¹⁶ For objections to Nordenfelt's theory see e.g. Brülde (2000a; 2000b); Venkatapuram (2013); Hoffman (2013b). See also Nordenfelt (2000; 2013a; 2013b) for replies to these objections.

¹⁷ The example of Liss' and Daniels' views reveals a common way to distinguish between theories of health, namely between biomedical (of which the bio-statistical theory is a sub-category) and holistic theories about health. Note that the notion of health care needs is in no way restricted to these two ways of understanding health.

¹⁸ Hope *et al.* (2010) draw on the work of Wiggins (1998) [1985] and argue that the goal component should be understood as harm-avoidance (see also Hasman *et al.* 2006). As I believe that the difference between harm-avoidance and advancement in well-being is primarily terminological I shall not discuss it further here.

¹⁹ A short note on the notion of well-being itself. Irrespective of which analysis of well-being one adheres to, it is only one respect in which a life may go well. Other respects may involve the life's moral value, its

Hedonistic theories according to which a life goes well if it contains a balance of pleasure over pain. The hedonistic thesis is that experiences of pleasure and pain are the *only* relevant elements for a person's well-being.²⁰

Desire-fulfilment theories according to which a life goes well if one gets what one wants, prefers or desires.²¹ A person's well-being is thus constituted by a balance of desire-fulfilment over having one's desires frustrated or having one's aversions fulfilled.²²

Objective list theories according to which a person's well-being is dependent on a number of objective values. These values are objectively good for a person in the sense that they are considered to be so, irrespective of that person's attitude towards them. Things that usually appear on such lists are freedom, love, pleasure and health.²³

Final and Operational Goals for Health Care

Crisp further argues that there is no need to settle for one rather than another of these theories in priority setting as "...most people enjoy and desire the items that are found on plausible objective lists..." (Crisp 2002, p. 136). On the contrary, Juth (2015) argues that the choice of theory makes quite a big difference with regard to priority setting decisions since different theories would give priority to different kinds of conditions.

Irrespective of who is right about this controversy it is important to note that these theories about well-being as goals for health care are candidates for the *final goal(s)* for health care, i.e. goal(s) that are worth promoting for their own sake. Moreover, as suggested above, a need principle may be combined with a variety of such final goals.²⁴

accordance with some moral standards or instrumental value, its being good as a means to a further goal. Thus, as a life may be good in many different respects it does not follow from that a life is good in just any respect that it is good for the person whose life it is. I understand well-being to be restricted to precisely this dimension of a life (see Sumner 1996, p. 20).

²⁰ For classical objections towards hedonism see Nozick (1974, pp. 40-44); Nagel (1979, ch. 1). See also Feldman (2004; 2010) for a contemporary discussion about hedonism.

²¹ Note that I refer to these theories as "preferentism" in paper I and paper II. However, this difference is merely terminological.

²² For an objection to desire-fulfilment accounts see Sumner (1996, esp. p. 136).

²³ For objections to objective list theories see for example Feldman (2004, esp. p. 19-20); Sumner (1996, esp. p. 45); Crisp (2008, esp. Sec. 4.3).

²⁴ The following discussion assumes that all relevant judgements about how badly off (or well off) people are can be made in terms of these theories. This means that there is no need to refer to any conception of disease or illness in order to make these judgements. See also Jebari (2015) who argues for the irrelevance of whether a given condition qualifies as a disease.

But how should one arrive at an answer to whether one of these theories is more plausible than another with regard to priority setting? What the goal(s) for health care should be is a normative question. The discussion about how the goal(s) should be characterised should therefore be guided by considerations about what it is valuable to achieve with a practice like health care (see also Juth 2015; Munthe 2000). Thus, a goal component must be discussed in relation to a *normative condition of adequacy* (I return to this notion in the methodology chapter).

However, even if there were convincing arguments for adhering to one rather than some other view about these final goal(s) one may still wonder what constituents of well-being *health care* should be concerned with. More specifically, what should be the operational goals for health care? In what respects should health care benefit patients?

It may be suggested that the operational goal(s) should neither be understood as health nor as well-being but as health-related quality of life. That is, the fraction of one's well-being that is determined by health (see e.g. Bognar & Hirose 2014). However, this view requires that one can separate the contribution health makes to one's well-being from other factors. This turns out to be notoriously difficult as different components of well-being interact in the sense that one is inseparable from the other.²⁵

A closely related answer to the question about the operational goal(s) for health care can be given by referring to a very simple idea about division of labour. The operational goal(s) for health care may be determined by the respects in which health care can rationally benefit the patient in order to achieve the final goal(s). Health care practices should, simply, be employed where the domain of health care may do better than other domains in society.

How to understand the final goal(s) as well as the operational goal(s) for health care more specifically are two important issues to answer in order to characterise needs for health care. However, in the following, I shall sidestep these questions and be satisfied with the tentative conclusion that while the final goal(s) has to be worked out by normative discussion, the operational goal(s) are closely related to the respects in which health care can benefit the patient.

²⁵ For a discussion of the so-called inseparability problem see further Bognar (2008); Hausman (2006).

In practice, health care systems seem to employ some loosely held together hybrid of the different theories of health and well-being described above.²⁶ However, irrespective of the precise nature of such a hybrid there is an important, often overlooked, question lurking in the background. As mentioned above, health care systems often rank condition-treatment pairs. Consequently, the assessment of how badly off (or well off) patients are, is based on how badly off (or well off) these patients are with respect to the specific condition that is targeted by the treatment (see e.g. Broqvist *et al.* 2011). This means that when a patient suffers from more than one condition the extent to which the patient is badly off is determined on the basis of how badly off he or she is with respect to *one* and not *all* of his or her conditions. Whether decision-makers base the assessment of how badly off patients are with respect to one or all of such patients' conditions makes a decisive difference with regard to priority setting. Therefore, it is important to discuss the moral questions that arise in relation to these different ways of assessing how badly off patients are.

Hitherto, I have discussed *what* should be distributed by a plausible principle of need. In the next section I shall move on to *how* the *what* should be distributed. I distinguish primarily between *what* a principle distributes and *how* the principle should distribute the *what*, in order to structure the discussion. This should not mislead the reader into believing that the *what* and the *how* questions are unrelated. For example, as I discuss in paper IV, while it may seem appropriate to distribute positions in a bureaucratic structure on the basis of merit it seems wrong to distribute emergency care on the basis of merit, and likewise, while it may seem appropriate to distribute emergency care on the basis of need it seems wrong to distribute positions in a bureaucratic structure on such a basis. Accordingly, *what* is distributed may have implications for *how* the *what* should be distributed.

²⁶ Consider for example a questionnaire like EQ-5D which is widely used in order to describe health states. The respondent describes how well he or she functions within five dimensions: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. The dimension of pain and discomfort may for instance be related to hedonistic theories as they are concerned with the patient's experiences, while the dimensions of mobility and self-care seem to involve fairly objective dimensions.

To Distribute Health Care According to Need

Ranking Needs According to Their Size

It is often assumed that the proper way to apply needs to questions about distribution is to adopt a principle that says that greater needs should take priority over smaller needs, or something to this effect (see e.g. Brülde 2011; Brülde & Persson 2011; Herlitz 2017; Ministry of Health and Social Affairs 1995a; 1995b). I shall refer to this approach as “ranking according to size”. To approach need-based priority setting by ranking needs according to their size has quite naturally led some people to believe that the crucial question is what determines the size of a need. This question has often, in turn, been interpreted to concern whether the concept of need refers (a) to how badly off a patient is or, (b) to a patient’s capacity to benefit from treatment (see e.g. Culyer & Wagstaff 1993; Culyer 1995; 1998; Cookson & Dolan 2000). These two interpretations of need are sometimes referred to as health need and health care need (see e.g. Liss 1993; Tinghög 2011), where the former denotes how badly off one is and the latter refers to a patient’s capacity to benefit from treatment.

I do not believe that this is a fruitful approach to understanding need as a distributive principle. From a normative standpoint it seems quite clear that a plausible principle of need should be characterised as a function of how badly off a patient is *as well as* to what extent a patient can benefit from treatment. Let me develop this idea in the following.

It is important to keep separate the claim that capacity to benefit should be taken into account by *some principle* within a pluralistic normative theory about priority setting from the claim that it matters from a principle of need’s point of view, so to speak. To keep these claims separate poses questions about how to handle the question about benefits within pluralistic theories about priority setting in which benefits may be accounted for by two (or more) principles. As this thesis primarily focuses on *need-based ideas*, it is a subordinated question how these ideas should be related to other principles within a normative theory about priority setting. Accordingly, it makes

perfect sense to discuss whether need-based ideas involve concerns for capacity to benefit, whether this is accounted for by other principles or not.²⁷

Some people accept that both dimensions matter but maintain that a principle of need ranks needs according to their size (Brülde 2011; Brülde & Persson 2011; Herlitz 2017). For example, Brülde & Persson (2011) suggest that the principle of need should be understood as saying that people with the greatest needs should receive more health care resources if there are effective treatments for these people.

A further example is Herlitz (2017) who plausibly characterises health need as a composite property constituted by health shortfall and capacity to benefit. However, he then makes the assumption that needs should be ranked according to size, which leads him to conclude that needs are indeterminate and the rest of the paper is spent on discussing how indeterminacy should be dealt with.

In the following, I shall argue that the idea of needs can be further refined with regard to distributive questions. The next section provides an argument for a different approach to applying health care needs to questions about distribution.

Needs as a Mid-Level Moral Principle

In the following, I shall argue that a principle of need should be understood in terms of a mid-level moral principle based on ideas about distributive justice. To understand needs in this way does not only open up the possibility of making more detailed need-based distributive judgements, it also provides a better account of why, or in virtue of what, people's need-based claims matter morally.

Suppose that an adherent of ranking according to size is pressed on *why* greater needs take precedence over smaller needs. To claim that the reason is that these people have the greatest needs is a non-starter as this would be a circular explanation. Rather, it seems that, as soon as the adherents of ranking according to size begin to specify why, or in virtue of what, greater needs should take precedence over smaller needs they have to make such specification in terms of ideas from distributive justice. For example, one may claim that one has a greater need and consequently a stronger need-based claim on a treatment because one is worse off than someone else or that one would benefit more.

²⁷ I return to this question in the chapter on further questions.

There are more promising ways to translate these dimensions of moral concern into distributive matters. However, one needs to manoeuvre carefully when applying ideas of distributive justice within a specific context, in this case priority setting. As the aim of this thesis is to characterise a principle of need applicable to health care priority setting it has to be characterised in relation to this particular context. While it is underpinned with substantial moral values, there may still be reasons to revise a principle in relation to the context in which it is supposed to be applied.

Without adhering to implausibly strong views such as saying that improvements in health should always take lexical priority over improvements in all other dimensions, it seems quite widely acknowledged that while it seems appropriate to distribute, say, Leonard Cohen's music according to some basic idea about supply and demand, few people seem to think that it is appropriate to distribute health care in this way. Therefore, the services provided by health care systems seem to be, at the very least, different from many other services. This is another example of how the *what* question influences the *how* question. There seems to be something special about being badly off with regard to the health care sector which makes such moral concerns especially important. Therefore, it may be that principles that in other contexts ascribe a given weight to the worse off do not ascribe *enough* weight to the worse off in a health care context.

This suggests that a principle of need for priority setting should be constructed as a mid-level moral principle (see e.g. Arras 2010). To approach the principle of need in this way is not to argue for the rightness of any high-level moral principle such as utilitarianism or (telic) egalitarianism (I discuss these views below). High-level moral theories aim to answer the question of what ought to be done, and why, in any possible situation. However, to argue for a mid-level moral principle is to assume it is useful for decision-making to characterise a principle of need for priority setting. Thus, a mid-level moral principle of need aims to give answers about how *health care* ought to be distributed. For example, the view sketched in paper III only claims to be plausible with regard to health care priority setting. It may be plausibly applicable to the distribution of other goods, but to what extent this is the case has to be addressed elsewhere. However, this does not mean that one should not draw on high-level moral theories about distribution when characterising needs as a mid-level moral principle. That is, while one should not simply copy high-level theories and paste them into just any context as mid-level moral principles, one can, and should, still use them as a part of one's tool box in

order to characterise such mid-level principles. Thus, in the following I shall assume that it is not primarily the *concept* of need that answers how resources ought to be distributed among needs. In order to answer this question one has to appeal to *substantial normative ideas* about how goods ought to be distributed. In the next section I shall discuss a number of ideas from the field of distributive justice that could be considered to be relevant in order to construct a principle of need for priority setting.

Needs in Terms of Distributive Justice

Ideas about justice relevant for constructing a principle of need as a mid-level moral principle are substantive rather than procedural. Substantive theories about justice involve ideas about how goods ought to be distributed, whereas procedural theories are concerned instead with the process according to which decision-makers arrive at a certain decision regarding distribution.²⁸ Before moving on to discuss a number of substantive theories about distributive justice I shall state some preliminaries for the following discussion. In the following I shall refer to the sense in which people are badly off (or well off) by referring to their level of health. I shall allow for the possibility of assigning levels of health represented by numbers to people, on a scale from 0-1 where 0 represents death and 1 represents optimal health,²⁹ and it will thereby be possible to say something about how badly off (or well off) these people are. Such an assumption is not unproblematic but seems necessary in order to properly discuss questions about distributive justice.

A plausible principle of need should not only include need-based ideas in the sense that it is recognisable as a principle of need; it should also be plausible from an ethical point of view. For example, a principle that implies that patients should be killed off whenever they experience pain would not pass.

²⁸ An influential procedural framework is “accountability for reasonableness” (see Daniels & Sabin 2002). A crucial question for such theories is whether the *outcome* of such processes may plausibly be viewed as fair merely in virtue of such an outcome being a result of a fair process. For example Daniels *et al.* (2016) argue in favour of such a position. See also Sandman & Gustavsson (2016) for an objection to such a position.

²⁹ I am simplifying here. To assume that death is the worst off one can be, and that there is an optimal level of health is not uncontroversial.

What does it mean to claim that a distributive principle should be “recognisable” as a principle of need? It means that the concept of need on which a principle of need is built implies certain normative characteristics. The conceptual structure of needs may, for instance, exclude certain normative considerations on conceptual grounds. For example, to construct a principle of need that ascribes moral weight to whether a patient deserves treatment or whether a patient can be held responsible for his or her condition seems to attach moral factors to need-based claims that are, simply, irrelevant for such considerations. This is not to say that such considerations may not be relevant for priority setting, but it does mean that such considerations are irrelevant for need-based claims.

Furthermore, the reference that several need theories make to harm-avoidance implies, for need principles, that morality requires a special concern for those who are worse off. In relation to this characteristic, consider how the utilitarian theory handles questions about distribution. Roughly speaking, utilitarianism has two components: the first component is a theory of utility itself while the second component is a principle that says that utility ought to be maximised. Accordingly, a utilitarian principle says that the net sum of utility should be maximised.³⁰ Due to the element of maximisation utilitarianism is indifferent to *how* the sum of utility is distributed, more specifically, among people. For example, utilitarianism may result in a distribution where a large group with small needs trumps a smaller group with greater needs due to the fact that the net sum of utility produced is greater in the former group than in the latter. This is a common objection to utilitarianism when it comes to distributive matters: it does not take suffering seriously enough or, alternatively, does not care enough about equal distribution. Thus, utilitarianism is not a plausible candidate for a principle of need.

The three theories outlined below give some kind of preference to the worse off. The challenge, in relation to the utilitarian theory, is to explain why and how a part of the net sum of utility should be “sacrificed”. This is done by appealing to some other value rather than maximising the net sum of utility. Note that the values that these theories

³⁰ For examples of the classic utilitarians see Mill (1998) [1861]; Sidgwick (1981) [1907]. See for example Singer (1993); Tännsjö (1998) for a more contemporary discussion of utilitarianism. Note that when I refer to the principle of cost-effectiveness I have something like this in mind. However, more specifically, the principle of cost-effectiveness says that *what* is distributed among patients should be maximised given available resources.

appeal to are final values as opposed to instrumental values.³¹ For example, the claim made by telic egalitarians, which I discuss below, is that it is bad in itself that some are worse off than others. This should be distinguished from instrumental egalitarianism which says that equality is valuable because equality tends to make people better off. Also utilitarians may agree that equality is instrumentally valuable to the extent it promotes maximising the good.

In the following, I shall outline three families of theories about distributive justice of which some may have more promising features for constructing needs as a distributive principle than others, namely egalitarianism, prioritarianism, and sufficientarianism.

Egalitarianism

Most egalitarian theories are based on the idea that something is supposed to be distributed equally among the people who are affected by the distribution. Egalitarians may still disagree about what it is that should be distributed equally. Some writers have argued that what matters is equality of opportunity while some have argued for equality of outcome (see e.g. Hirose 2015a). Equality of opportunity implies a focus on an equal opportunity for people to achieve some reasonable level of health or perhaps better their greatest potential for health. This idea entails that people have different starting points from which they may achieve a good state of health, and people should be compensated for these inequalities.

Egalitarianism may be further distinguished between Rawlsian egalitarianism and telic egalitarianism. Rawls (1971) famously discussed what constitutes a just society. As a part of his theory of justice Rawls (1971, p. 53) stated the difference principle which says that “...inequalities are to be arranged so that they are...to the greatest benefit of the least advantaged...”.³² Accordingly, the difference principle does not really aim at equality in terms of outcome. It rather says something about under what circumstances

³¹ Note that I distinguish between final value and instrumental value, rather than between intrinsic value and instrumental value. Final value may be further distinguished between extrinsic and intrinsic final value. That something has final intrinsic value means that it is valuable in virtue of its intrinsic properties. That something has final extrinsic value means that it is valuable in virtue of its relational properties. In this thesis I assume that the crucial aspect of final value is that it refers to value for its own sake.

³² More specifically, Rawls’ theory is constituted by three principles of which the difference principle is one. For reasons of simplicity I ignore its relation to these two other principles and relate to the difference principle as a possible specification of a principle of need.

inequalities are justified and this is the sense in which Rawlsian egalitarianism gives special consideration to the worst off.

Telic egalitarianism says that people ought to be compensated in such a way that they achieve as equal outcome as possible. This, in practice, often implies giving special consideration to the worst off. A somewhat standard objection to telic egalitarianism is the so-called “levelling down objection” (see Parfit 1995). The problem arises from the fact that the egalitarian notion of justice is comparative which means that the theory focuses on how well off people are *in relation to* other people. Accordingly, the egalitarian has to claim that an outcome is better (at least in one respect) when some individuals among the best off are made worse off without anyone being made better off. As egalitarians are usually pluralists with regard to value they need not claim that equality is the only value that should be promoted for its own sake but that this is one respect in which an outcome may be made better or worse. Therefore, when this objection is directed towards egalitarian pluralists the objection must be, as Parfit (1995, p. 211, my italics) states: “...if we achieve equality by levelling down, there is *nothing* good about what we have done”. But this is precisely the claim that egalitarians want to make: an outcome can be better in *one* respect by levelling down but worse in another, but more importantly, this is not necessarily to claim that if equality is achieved by levelling down, an outcome is better all things considered (see further Temkin 1993).

Prioritarianism

It is sometimes argued that people who believe that the best distribution is the one that strives towards equality are mistaken. What these people actually have in mind is not that equality is desirable for its own sake but that it matters more to benefit someone the worse off that person is (see e.g. Parfit 1995; Arrhenius 2012).

Parfit (1995, p. 213) influentially characterised the priority view in the following way: “Benefiting people matters more the worse off these people are” (see also Parfit 2012). What, then, is the difference between telic egalitarianism and the priority view? Parfit summarises this well in the following passage: “Egalitarians are concerned with relativities: with how each person’s level compares with the level of other people. On the Priority View, we are concerned only with people’s absolute levels” (Parfit 1995, p.

214).³³ This is the chief structural difference. By understanding how well off people are in absolute terms, the priority view avoids the levelling down objection.³⁴

Arneson (2002) suggests that prioritarianism may be described as constituted by the following two theses: (i) maximising the good, and (ii) priority for the badly off. Accordingly, on one extreme most weight would be put on the former principle and would then barely be distinguishable from the utilitarian principle while the other extreme would give most weight to the latter thesis and would then be barely distinguishable from Absolute Priority, the view that one should always give absolute priority to the worst off. It seems, however, that irrespective of how one ascribes weight between these two components, the priority view may still imply a distribution where a large group with very small needs trumps a smaller group with much greater needs, given that the large group is large enough (see Crisp 2003; Otsuka & Voorhoeve 2009).³⁵

Sufficientarianism

Sufficientarianism was developed by Frankfurt (1984; 1987), at least in part, as a reaction to egalitarianism. In contrast to the egalitarian theory and like the prioritarian theory, the sufficientarian theory focuses on absolute levels. However, what matters morally is not equality, neither do benefits have diminishing moral importance as adherents of the priority view argue. The starting point for the sufficientarian is that people should have sufficient or enough of what is good. Hence, the way in which goods are distributed only matters up to a certain level which includes what one needs, for example, in order to live some kind of minimally good life.

Sufficientarianism is constituted by two theses, sometimes referred to as the positive thesis and the negative thesis. The former implies that people below the threshold should be lifted so that they are located above it. The latter entails that there are no

³³ See also Broome (2001); Crisp (2003). For a recent discussion on the priority view see the special issue in *Utilitas* volume 24, number 3, 2012.

³⁴ At least this is what many writers take as a reason to adhere to priority rather than equality. It has recently been argued, however, that the priority view is not immune to levelling down (Persson 2008; 2011).

³⁵ See further Arrhenius (2012, p. 170) who questions whether the priority view really implies any specific methodology for aggregation. See also Tännsjö (2015) for another recent criticism of the priority view.

reasons, or weaker reasons,³⁶ to additionally lift the people already located above the threshold further (Benbaji 2005; 2006; Casal 2007; Crisp 2003).

Note that these two theses do not, by themselves, have any implications for the question about how to prioritise among the people below the threshold. Hence, sufficiency principles need to be combined with some other distributive principle in order to constitute a more comprehensive distributive principle.

A common objection to this kind of theory is that it seems difficult to find a non-arbitrary way to set the threshold level. Moreover, it seems difficult to argue convincingly for why one should give *absolute* priority to people just below the threshold and *no* priority to people just above the threshold (see e.g. Casal 2007).

Characterising Needs with Respect to Aggregation

To construct theories about distributive justice is a complex business. Therefore, I shall focus on how to characterise a principle of need with regard to two respects which are both related to how a principle of need should handle questions about aggregation. In the following, when I refer to the notion of aggregation, I refer to a process according to which a value is assigned to a whole by assessing the parts of that whole (Hallingday 2011, ch. 2; Hirose 2015b, ch. 2). This definition of aggregation is compatible with intrapersonal aggregation as well as interpersonal aggregation. I shall outline this distinction in the following.

First, in relation to *what* is distributed, it is far from settled how a principle of need should be characterised with respect to handling questions about intrapersonal aggregation. The notion of intrapersonal aggregation has been surprisingly overlooked in the philosophical discussion.³⁷ As it turns out, this notion of aggregation may play quite a decisive role in determining who is worse off when people have more than one condition for which they need health care. According to Hirose (2013, p. 182) intrapersonal aggregation “...concerns how the temporal parts of a person’s life are combined within his life.” Note that Hirose takes intrapersonal aggregation to focus

³⁶ See for example (Crisp 2003) who argues that a utilitarian principle may be employed above the threshold.

³⁷ For an exception see Hirose (2015b, pp. 89-105).

exclusively on how the *temporal* parts of a person's life are combined. I shall employ a wider understanding of intrapersonal aggregation according to which it may be concerned with how different parts or dimensions (which are not primarily temporal) of an individual's life are combined.³⁸

Second, in relation to *how* the *what* is distributed, interpersonal aggregation refers to moral trade-offs between different groups. The underlying idea of moral principles that aggregate is that benefits accruing to one group can morally outweigh the losses that accrue to another group (see Hirose 2013, p. 185). The theories about distributive justice that I have outlined above all ascribe importance to the worse off, which is well in line with a principle of need. However, none of these theories give a satisfying answer to the question of how principles of need should handle issues about aggregation. How distributive principles handle questions about interpersonal aggregation may have decisive implications for how these principles distribute goods among patients.

Problems and Questions

In this chapter I have sketched the background against which the central questions for this thesis arise. A first rough categorisation of the problems I shall discuss would be to say that, on the one hand, there are a number of conceptual problems that need to be discussed, and on the other hand, there are a number of normative questions that need to be discussed. Let me cluster the problems that I shall discuss, first, in terms of conceptual questions and, second, in terms of normative questions.

First, as regards the conceptual questions, what is a need? When does one have a need, and more specifically, when does one have a need for health care? What is the difference between needing health care and wanting health care? Are needs independent of what one wants? What queries arise when a patient introduces his or her preferences about his or her care alongside a need-based approach to priority setting?

Second, as regards the normative questions, how should need-based ideas be characterised in priority setting? More specifically, how should principles of need be characterised with regard to questions about aggregation? How should principles of

³⁸ See also Kamm (2002) who employs a broader interpretation according to which it aggregates different morally relevant factors intrapersonally, and in this way adds up to a total sum of one's claim on resources.

need handle interpersonal aggregation, i.e. the aggregation of benefits across individuals? How should principles of need account for the fact that patients are often badly off due to several rather than one single condition, i.e. questions about intrapersonal aggregation?

In light of this background chapter and these questions, I shall in the following chapter specify the overall aim of this thesis as well as the specific aim of each of the articles that constitute the basis for this thesis.

AIM

Overall Aim

People (laypersons, health care professionals, participants in the public debate, policy makers, patients) employ the term “needs” as a reason to distribute health care in a specific way on an individual level as well as on a group level. However, whether referring to the former or the latter, it is somewhat unclear what these people have in mind more specifically. The overall aim of this thesis is to explore how needs should be characterised in health care priority setting.

In order to achieve this overall aim the idea of needs is approached in two ways. The first approach aims to explore the *conceptual structure* of needs in general and health care needs in particular. This conceptual approach also involves an analysis of how needs in general and needs for health care in particular relate to closely related concepts such as desires or preferences for health care.

The second approach aims to explore how a plausible principle of need should be characterised in order to serve as a *normative principle* for health care priority setting. More specifically, the second approach concerns how principles of need should handle questions about inter- as well as intrapersonal aggregation of value (and disvalue).

Through approaching needs in priority setting in these two ways this thesis aims to contribute to the interdisciplinary discussion about health care priority setting in general and to the discussion about health care needs in the philosophy of medicine and medical ethics in particular.

Article Specific Aims

Article I explores how the concept of need is understood in the general philosophical discussion. The aim of this paper is to characterise a plausible conceptual structure for health care needs drawing on this philosophical discussion.

Article II examines how needs for health care relate to a patient’s wants within shared decision-making. The aim of this paper is to explore how the notion of need relates to the increasing focus on the notion of shared decision-making in general and the patient’s preferences brought out by such practices in particular.

Article III investigates how a principle of need ought to handle questions about interpersonal aggregation. The aim of this paper is to characterise and defend a principle of need that finds a reasonable middle ground between how the principle of cost-effectiveness handles questions about aggregation and how non-aggregative distributive principles handle such questions.

Article IV discusses how a principle of need should account for the fact that patients often suffer from multiple conditions rather than one single condition. The aim of this paper is to argue that severity in cases of multiple conditions should be understood as how badly off patients are when all of their conditions (for which they need health care) are considered.

METHODOLOGICAL DISCUSSION

To characterise needs in priority setting in the respects presented in the previous chapter requires a conceptual analysis of the notion of needs as well as health care needs and moral reasoning about principles of need. These two approaches involve two methods: conceptual analysis and reflective equilibrium. The former concerns the conceptual study while the latter is concerned with moral reasoning. In this chapter I shall first discuss conceptual analysis and, second, I shall move on to discuss reflective equilibrium.

Conceptual Analysis

In ordinary language as well as in official guidelines, concepts are often used in an ambiguous manner and notions are sometimes confused with each other. To make sense of such matters philosophers traditionally pursue conceptual analysis. The aim of conceptual analysis is, in the words of Nordenfelt (1995, p. 11), “...to find a core element in prevalent uses of the term...and try to develop it in such ways that it will become coherent and useful for scientific purposes. The aim is not merely one of lexicography, but also of logical reconstruction: to sharpen the borders of the concept...”. Note that “scientific purposes” is a little misleading in this context since the purpose of the concept of health care need is not related primarily to scientific practices. Rather, it has a more practical purpose,³⁹ namely to provide a basis for priority setting. Accordingly, the aim here is not to arrive at the “right” definition of health care need. I shall rather approach the process of conceptual analysis as being essentially purpose-driven. Note that these claims do not mean that progress cannot be made in this area. It makes better sense to say that the aim is to arrive at the “best” concept of health care need in the light of some predefined purpose(s). In order to arrive at such a concept one gives different weight to different *conditions of adequacy* formulated in relation to some

³⁹ See Brülde (2010); Brülde & Tengland (2011); Munthe (2000) for examples of how conceptual analysis in a health care context is best understood as having a practical purpose.

predefined purpose, and judges the pros and cons with different options. The best concept will be determined by the extent to which it satisfies the best weighing of the relevant conditions of adequacy. Even though such conditions are usually not explicitly stated when philosophers conduct conceptual analysis, they are often implicitly assumed. In other words, conceptual analysis, as employed in this thesis, is the process of negotiation between a number of specified conditions of adequacy in relation to a purpose. The purpose of the definition determines the reasonableness of these conditions.

In this thesis, I assume that the concept of health care need should satisfy, at least, the following three purposes. First, the conceptual analysis undertaken in this thesis provides a conceptual framework for a common discussion. To make the constituents of needs explicit facilitates an informed discussion about needs for health care. In particular, it is important to explicate how values are involved in needs, as people tend to disagree about evaluative standpoints.

Second, distributive principles in general, including principles of need in priority setting, are concerned with the allocation of resources among what Hirose (2015a) refers to as *entities with moral standing*. For example, when John Rawls states that non-human animals fall outside the scope of his theory of justice he excludes animals from entities with moral standing (relevant for his theory of justice). But what makes a person qualify as an entity with moral standing within the health care sector? A reasonable starting point here is to say that a person should have a need for health care. Accordingly, the second purpose of the concept of health care need is to determine candidates for need-based claims on health care resources.

Third, as I have argued above, and will argue further below, the best approach to characterising a principle of need is to do so in terms of distributive justice. However, a principle of need cannot be completely detached from conceptual ideas about needs. A need principle must be recognised as a principle of need, and not something else. A *principle* of need should therefore be characterised on the basis of a *concept* of need.

In order to satisfy these three purposes there are a number of relevant conditions of adequacy between which one needs to negotiate. In the concluding discussion I shall discuss the conceptual analysis which is pursued in this thesis in relation to the following conditions of adequacy.

The ordinary language condition, which says that a definition should not deviate too much from ordinary language, how a concept is ordinarily used (or “the prevalent uses

of the term”). This condition is relevant, primarily, in relation to the purpose of serving as a basis for the construction of a principle of need. If a principle of need is to be recognised as a principle of need it should rest on a concept of need which does not deviate too much from ordinary language.

The value condition, which relates to the value-laden aspect(s) of the notion undergoing analysis. A good definition should, for example, explain *in virtue of what* health care needs are morally relevant, and consequently, why it is bad for a person to have needs for health care that are not fully satisfied. This condition is relevant in relation to the purpose of determining *entities with moral standing* as it explains in virtue of what a person qualifies as such an entity.

The precision condition says that a definition should be sufficiently precise. At least in principle it should be clear that a certain state qualifies as a need for health care. This condition is relevant in relation to the purpose of characterising a need principle. Needs for health care should, for instance, be distinguishable from demands for health care.

The simplicity condition has two aspects. First, it is preferable that a definition can make sense of needs in terms of one criterion rather than a conjunction or a disjunction of criteria. Second, a theory which does not contain ad hoc solutions or modifications is preferable over a theory which does so. This condition is relevant in relation to the purpose of making sense of and discussing needs for health care. A simplified concept enhances a simplified discussion.

These conditions are conditions of adequacy that may be derived from a certain aim but they do not in themselves constitute such aims. There may also be some conditions of adequacy which in themselves constitute a certain purpose. That is, such conditions specify certain normative work which the concept should be able to do. The purpose of serving as a basis for characterising a principle of need may be understood as a *condition of normative adequacy* (see Brülde 2010; Brülde & Tengland 2011; Munthe 2000). Accordingly, a conceptual analysis of the notion of need interplays, to some extent, with the moral reasoning about how a principle of need should be understood. However, in order to arrive at reasonable normative standpoints one needs to turn to another approach, namely reflective equilibrium, which I shall discuss in the next section.

Reflective Equilibrium

In paper III and paper IV as well as in the concluding discussion I attempt to arrive at well-grounded normative positions. Accordingly, it is an underlying assumption for the discussion in this thesis that some moral judgements are more justified than others. In this section I shall discuss moral justification and moral methodology in terms of reflective equilibrium.

The notion of reflective equilibrium was introduced by John Rawls in *A Theory of Justice* published in 1971. Reflective equilibrium is primarily a theory about what makes moral judgements epistemically justified; however, it is often related to as a method for moral reasoning (see e.g. Beauchamp & Childress 2001; Daniels 1996; 2011; Petersson 2000; Scanlon 2003; Tersman 1993). Moreover, it is sometimes used to denote the goal or end-point of such a process, namely where moral judgements cohere (and then, supposedly, are justified). Since it is doubtful that one ever reaches such an ideal state, as also acknowledged by Rawls (1971, p. 49), it is more appropriate to think about the goal of the process of moral reasoning as arriving at “resting points” rather than “end-points”.

In the following, I shall first discuss reflective equilibrium as a method of moral reasoning according to which one arrives at a given resting point and, second, as a theory about epistemic justification of the moral judgements in a given resting point.

Reflective Equilibrium as a Method for Moral Reasoning

The process of reflective equilibrium is a working back and forth between: (a) one’s considered moral judgements or intuitions (I use these terms interchangeably) about particular cases, and (b) moral principles. The first step in this process may be described in the words of Tersman (1993, p. 47), it “...begins with filtering one’s moral views so that one is left only with those qualifying as considered judgements...”.⁴⁰ For a belief to qualify as a considered moral judgement it should meet a number of requirements. For

⁴⁰ See also Scanlon (2003) who sketches the process in much the same way. As far as I can see there is no reason why one cannot, first, start the process with a moral principle and, second, revise the principle in a way that makes it account for considered judgements. As I understand Tersman as well as Scanlon this is just how the process normally goes in practice, something strikes one as morally wrong and then one tries to account for why this may be so.

example, it should be of the kind in which one has strong faith, about which one has the relevant information, and it should not be best explained by one's self-interest or prejudices.

The second step is to formulate moral principles that can account for the considered judgements. These principles may vary in their degree of specificity (Rawls 1974-75, p. 8), they may be of the general kind such as "euthanasia is wrong" or more specified such as "euthanasia is wrong if it is not offered to terminally ill people".

Note that the considered moral judgements may also vary in their degree of specificity. Accordingly, there is no clear-cut line between what qualifies as a considered moral judgement and what qualifies as a moral principle.

The third step then involves a working back and forth, sometimes modifying the considered judgements and sometimes modifying the moral principles, evaluating and revising each category on the basis of the other while striving for coherence.

An important underlying assumption of the process of reflective equilibrium is that even if there are what Rawls referred to as "fixed points", but which may be better expressed in the words of Tersman (1993, p. 3): "...some initial beliefs with strong initial acceptance..." or in the words of Daniels (my italics, 1979, p. 267): "...*provisional* fixed points...", it is important to stress that (as also emphasised by Rawls, Tersman, and Daniels) even though these fixed points may serve as a starting point, they are always revisable. Hence, there are no considered moral judgements and no moral principles that are immune to revision.

The moral principle underlying the project undertaken in this thesis is that some kind of special concern should be given to the worse off. This is a plausible candidate for an "initial belief with strong initial acceptance" from which the process of reflective equilibrium begins. As a second step, one may attempt to specify this principle by formulating a principle according to which absolute priority should be ascribed to the worst off. However, giving absolute priority to the worst off clashes with a moral principle according to which it matters, at least to some extent, how much good can be produced for a given resource. A principle that ascribes absolute priority to the worst off should therefore be revised on the basis of the concern for produced goods. The next step is to formulate a moral principle that can account for both these aspects, and so the process continues until it temporarily stops at some resting point.

Reflective Equilibrium as a Theory About Moral Justification

At a given resting point in the process of reflective equilibrium, the judgements within a set are epistemologically justified in virtue of them being coherent. This makes reflective equilibrium a coherentist view, as opposed to a foundationalist view, of epistemological justification of moral beliefs. Foundationalism is the view that there is some epistemically privileged class of moral beliefs that enjoy their privilege irrespective of their relation to other beliefs (see further e.g. Shafer-Landau 2007). The coherentist rejects that there is any such privileged class of moral beliefs and holds that such beliefs are justified in virtue of their relation to other beliefs. It follows from coherentism that there is no independent standpoint from which one may say that one intuition or principle should outweigh some other intuition or principle.

Following Tersman (1993, p. 41), I shall assume that it is not the case that some moral judgements are justified and some are not; rather, moral justification is a matter of degree. Adherents of coherence theory tend to agree that logical consistency among a set of beliefs is a necessary but not sufficient condition for coherence. A set of beliefs is consistent if all beliefs in that set could be true together at the same time. In order to increase the justificatory force of a set, one should also strive to ensure that members of a set are mutually supportive and explanatory (see e.g. Tersman 1993, p. 33; Daniels 2011, p. 2).⁴¹ Moreover, there is a general tendency among coherence theorists to believe that large justificatory circles are better than small ones. Hence, the aim here is not to achieve mere coherence but coherence among a large set of beliefs.

Hitherto I have said that members within a set are coherent in virtue of them being consistent as well as mutually supportive and explanatory. However, in order to be relevant to the *ethical* discussion of priority setting the members of a set must also be part of a wide (as opposed to a narrow) reflective equilibrium (see further Brännmark 2013; Daniels 1979; 2011; Rawls 1974-75; Tersman 1993). This means that a principle of need should be tested against other relevant moral principles. For example, the reasoning in paper III arrives at a view about how a principle of need should handle

⁴¹ See also Shafer-Landau (2007). There is much more to be said about coherence in general and reflective equilibrium's relation to coherence in particular. To provide a full discussion of these issues is far beyond the scope of this thesis. Hence, I shall assume rather than argue that questions about moral epistemology and justification is best understood in terms of coherentism.

questions about interpersonal aggregation, which is referred to as Double Threshold Priority. An important part of the reasoning that leads up to this resting point is to consider leading alternative views on how questions about interpersonal aggregation should be handled. Hence, the more relevant alternative views one considers, before one arrives at a given resting point, the more justificatory force that resting point has. For example, the reasoning in paper III rejects the utilitarian as well as the prioritarian approach to aggregation on the grounds that they do not give enough weight to the worse off, something that a principle of need should account for. If these alternative views were not considered, the process in paper III would be better described as a narrow reflective equilibrium and consequently would have weaker justificatory force. Hence, this version of wide reflective equilibrium refers to an extension of the process in terms of alternative views that may provide additional justificatory force.⁴²

Before I conclude this section I want to emphasise that the role of moral intuitions is not unproblematic. Moral intuitions are shaped by a number of factors, some of which we are (at least partly) aware, such as cultural environment and religious heritages, but also by a number of factors of which we are not (yet) aware.⁴³ However, this is not a well-founded criticism against reflective equilibrium. Rather, this is precisely why these intuitions should be scrutinised in the light of other moral intuitions and moral principles. If one is sceptical about moral intuitions, due to for example their origin, a fruitful approach is to question and scrutinise these intuitions on the basis of other moral beliefs. Reflective equilibrium is a suitable framework within which such questioning may be carried out. Hence, sceptics about moral intuitions should not reject reflective equilibrium; they should get involved in it.

⁴² Moreover, wide reflective equilibrium is sometimes understood as including relevant background theories in moral reasoning (see e.g. Daniels 1979; 2011). I shall not discuss the role for such background theories here; however, I briefly return to wide reflective equilibrium in terms of alternative views in the chapter on further questions.

⁴³ See further Singer (2005) for criticism about the role that reflective equilibrium ascribes to intuitions. For convincing replies to Singer's criticism see for example Juth & Sandberg (2009); Tersman (2008, esp. pp. 394-396).

SUMMARY OF ARTICLES

This chapter provides a summary of each article, whereas their conclusions are brought together and further discussed in the next chapter. The primary focus for paper I and paper II is conceptual questions about needs for health care, while paper III and paper IV undertake a moral discussion about principles of need with a special focus on how such principles should handle questions about aggregation.

Article I: “From Needs to Health Care Needs”

This paper explores the conceptual structure of needs in general and health care needs in particular, drawing on the general philosophical discussion about needs. The paper discusses three conceptions of needs: need in an instrumental sense (IN), need in a categorical sense (CN) and, need in a dispositional sense (DN). The underlying motivation for writing this paper was two-fold. First, the *concept* of health care need had been somewhat overlooked in the discussion about priority setting, and second, some writers seemed to believe that only CN could account for the moral weight of needs. Whereas these writers claim that needs that carry moral weight are conceptually dependent on the concept of harm, this paper argues that there is no point in assuming that there are two different *concepts* of need. Rather, the relevant difference between the three different conceptions boils down to how the goal component is characterised. The paper concludes that one can say everything one wants to say and make all the moral judgements one wants to make with IN. Therefore, the distinction between, on the one hand IN, and on the other hand CN and DN, is superfluous with regard to health care needs. Furthermore, as regards the sense in which health care needs may carry moral weight, there is no reason why IN could not be combined with a theory about what is valuable for people, and accordingly provide moral reasons. Rather, the best analysis of health care needs says that while all needs are instrumental they derive their moral weight from the goal component.

Moreover, following the philosophical tradition sketched in the background chapter, need is analysed as a three-place predicate. However, the conclusion in this paper

deviates from this tradition in that it concludes that the concept of need should be understood in a specific way when moving from needs to health care needs. Whereas the traditional analysis of needs says that *Y* should be understood as a necessary condition for *Z*, this paper argues that needs for health care should be understood as *Y* being potentially beneficial for *X* in order to achieve *Z*.

Article II: “Health-Care Needs and Shared Decision-Making in Priority-Setting”

There is a general tendency to make health care more patient-centred. This article focuses on the potential tension between the patient’s need for health care and the patient’s desire for health care within the practice of shared decision-making. The aim of this paper is to make sense of the potential tension between needs and desires.

The paper distinguishes between needs and desires in terms of objectivity. It argues that a need may be objective in, at least, the following two senses: first, a need may be objective with respect to the relation between an intervention and the goal component. In this case a need is objective in virtue of the relation being independent of the person’s beliefs about it. Second, a need may be objective in virtue of its goal component being objectively good for the person in the sense that it is good for the person irrespective of that person’s attitude. The paper concludes that health care needs are objective only in the first sense.

The paper then elaborates on the complex relation that may obtain between needs and desires by discussing a number of cases in which people’s needs and desires interact in various ways. The discussion about these cases suggests, first, that a person’s preference seems to affect the extent to which that person needs an intervention, and second, that a person’s preference may go in a different direction than the person’s need does.

It is then asked how to make sense of these complex relations. The paper discusses two ways in which the tension between needs and desires can be conceptualised: volitional needs and non-volitional needs. The paper argues that it seems right to understand the cases in terms of volitional needs, that is, where desires may partly constitute (but not necessarily exhaust) a person’s need.

Furthermore, the cases bring out a number of queries that arise due to this double focus. First, as the room for the patient's desire expands in a shared decision-making process, the room for understanding needs in the objective sense (as the goal being objectively good for the patient) diminishes. Second, when needs have been assessed on the group level and decisions are to be taken on the individual level it is more difficult to predict what patients will appear on the individual level. Third, the complex relation between needs and wants also poses questions about how these factors affect patients' need-based claims. Fourth, the double focus of needs and desires poses difficulties with regard to understanding how patients are benefited, as well as practical implications for evidence-based medicine.

Article III: "Principles of Need and the Aggregation Thesis"

This article focuses on how a plausible principle of need should handle questions about interpersonal aggregation. On the one hand there are people who believe that a need principle should aggregate in much the same way as the priority view does; on the other hand, there are people who believe that plausible principles of need should be characterised as non-aggregative.

This paper argues that a plausible principle of need can neither be constructed as a prioritarian principle, as such a characterisation would not give enough weight to the worst off; nor can a plausible principle of need be constructed as a non-aggregative distributive principle, as if so constructed it would not ascribe enough weight to how benefits are distributed. Against this background the paper sketches a version of a need principle, which is referred to as Double Threshold Priority (DTP), consisting of a prioritarian element as well as elements of sufficiency.

DTP is constructed in the following way. On a scale of health from 0-1, the priority view holds all the way from 0 to 1, and accordingly it matters more to benefit people the worse off these people are. Furthermore, in order to strike the right balance between concerns for the worst off and how benefits are distributed, DTP also contains two thresholds, for instance one at 0.2, and one at 0.8. These thresholds allow for ascribing absolute priority to the worst off in a limited sense. This is done in the following way: trade-offs are allowed between, as well as within, the groups, with one exception.

Decision-makers are not allowed to make trade-offs from the worst off people (the people below the lower threshold) in favour of the best off (the people above the upper threshold). Hence, DTP gives absolute priority to the worst off over the best off, but not over the moderately badly off (the people between the thresholds).

The last section in the paper defends DTP from a number of objections. As it turns out, when it comes to answering these objections adherents of DTP are not in a worse position than adherents of the priority view (stated by itself).

Article IV: “Patients with Multiple Needs for Health Care and Priority to the Worse Off”

This article discusses how principles of need should account for the fact that patients are often badly off due to several rather than one single condition. Decisions about priority setting are often based on how badly off patients are with respect to the condition targeted by the treatment whose priority is under consideration. This paper distinguishes such a sense of severity, referred to as *condition-specific severity*, from how badly off the patient is when all of the patient’s conditions are considered, referred to as *holistic severity*.

The article further argues that if a principle of need is to be characterised in a way that reflects the morally relevant sense of being worse off it should be characterised as assessing severity in the holistic sense. The paper considers an argument put forth by Greg Bogner, which draws on the notion of sectorial justice, which could be developed into an argument for adhering to the condition-specific account. As it turns out, this approach lacks any underlying moral justification for adhering to the condition-specific account. The analysis of this argument also suggests that a principle of need that is constructed with the condition-specific account results in counterintuitive distributions with regard to priority setting.

The last section in this article is devoted to a somewhat different thesis, namely that when people are among the worst off, small differences in severity cannot be decisive in determining people’s need-based claims. The holistic account is discussed in relation to ideas put forth by Frances Kamm according to which some differences in need may, under specific circumstances, be irrelevant for determining what ought to be done. To establish this thesis in the present context strengthens the holistic account as if so constructed it avoids some counterintuitive outcomes.

CONCLUDING DISCUSSION

The following chapter aims to bring together the conclusions from the articles by specifying, first, a number of conditions of adequacy that a plausible characterisation of the concept of health care need should fulfil and, second, specifying a number of conditions of adequacy that a plausible principle of need should fulfil. Furthermore, as the discussion unfolds in the following, I will encounter some questions that need to be clarified and some questions that deserve further attention.

The Concept of Health Care Needs – *the difference criterion*

In this section, I shall primarily synthesise some of the discussions from paper I and paper II by sketching a number of criteria that should be fulfilled in order to constitute a health care need. In order to facilitate the following discussion, recall the conditions of adequacy for conceptual analysis outlined in the methodology chapter: *the ordinary language condition*, *the value condition*, *the precision condition*, *the simplicity condition*, and *conditions of normative adequacy*. Recall also the three-place structure of needs according to which some subject *X* needs some object *Y* in order to achieve some goal *Z*.

In paper I, I discuss the conceptual structure of needs in general and health care needs in particular. I argue that three conceptions of need collapse into an instrumental analysis. Therefore, I argue, it is not relevant to distinguish between different *concepts* of need (such as between categorical and instrumental). The relevant question is rather how the goal component *Z* is understood. The importance of how one understands the *Z* component arises from the fact that it is a necessary condition for a health care need that there is a difference in *Z*. Thus, the first criterion for health care need may be formulated.

The difference criterion. *X*'s condition is such that there is a difference between *X*'s actual (current or risk-related) level of *Z*, and some higher level of *Z*.

As I have argued in the methodology chapter, one of the purposes of the concept of health care need is to capture plausible candidates for carrying need-based claims. Thus, a necessary condition for a person to qualify for carrying such a claim is that there is a difference between X 's actual level of Z and the higher level of Z . Note that by referring to X 's "higher level of Z " the concept is open with regard to whether this refers to achievable, optimal, or some average level of Z . *The difference criterion* indicates that X has some kind of shortfall, for example some disease, illness, discomfort or suffering. Note also that this formulation is open with regard to how large this difference is.

As mentioned in the background chapter several need theorists take Z to be objectively good for people in the sense that it is good for them irrespective of their own assessment. The discussion in paper II suggests that this is not a plausible characterisation of health care need. Consider The Pianist Case, discussed in paper II, in which the piano player Mary and Professor Margaret both suffer from a hand injury. To restore Mary's hand demands more resources than to restore Margaret's hand. Whereas both have, quite naturally, a preference for their hand to regain function, Mary's preference may play a significantly different role, related to her preference for being able to play the piano again.

The normative question arising here is whether Mary should be assigned a stronger claim on resources than Margaret. On the assumption that she should, the question at stake is, more specifically, whether Mary has a stronger *need-based* claim on resources than Margaret. The puzzle here is whether The Pianist Case is best accounted for by saying that (a) Mary has a stronger need-based claim than Margaret in virtue of her need being partly constituted by her preference for playing the piano, or (b) Mary and Margaret's need-based claims are equally strong; however, in addition to her need, Mary has a preference which *also* should be taken into account in priority setting. Should Mary's preference be understood as (a) a constituent of her need or as (b) *another* reason to prioritise Mary?

The discussion in paper II leans towards (a). In the following I shall attempt to strengthen the appeal to (a) rather than (b). I believe that The Opera Singer Case from paper II brings out a crucial conceptual intuition. William takes a diuretic as part of his treatment and wants to reduce his intake from six pills (which decreases the risk for

future complications by 90 %) to three pills (which decreases the risk by 45 %) in order to avoid constant visits to the bathroom.⁴⁴ To sing the opera is an important constituent of a good life for William and as his performances often last up to four hours he strongly desires to avoid constant visits to the toilet, even if the price to pay is an increased risk of future complications. It seems somewhat counterintuitive to say that a person needs a treatment in order to achieve a *Z* which is incompatible with his own perception of a good life, that he needs something that will be worse for him.

The Opera Singer Case suggests that a need constructed with a *Z* without any subjective component has little impact on what ought to be done. If needs were characterised in this way, the connection between the course of action implied by needs and the course of action that ought to be done is, simply, too weak. I believe that the case for (a) can be made stronger if one considers a case with the same structure as The Opera Singer Case but in which side effects are more severe.

Consider The Stamp Collector Case in which Bill has a risk-related condition *C* for which there are two treatments *A* and *B*. There is a given probability *P* that *C* will result in very severe impairment. Treatment *A* will reduce *P* by 70 % while treatment *B* will reduce it by 80 %. Whereas *A* has no side effects, *B* makes patients colour blind. For Bill, it is an easy choice to increase the risk of future impairments in order to maintain his sight intact as he loves and has always loved collecting stamps (and in order to fully appreciate the beauty of his stamp collection he needs to see their colours). He therefore prefers treatment *A* as treatment *B* would make him unable to live his life in accordance with his perception of a good life, of which the ability to appreciate his stamp collection is an important constituent.

As far as I can see, if one accepts that William needs six pills but wants three, one has to say that Bill needs *B* and wants *A*. However, again, there is something counterintuitive in saying that Bill needs something that will be worse for him. This suggests that what one needs cannot be completely independent from one's view of what constitutes a good life. This is a reason to understand health care needs as being partly constituted by preferences.

⁴⁴ In sketching this case in paper II William went from ten to five pills. However, as suggested to me by the editor for Gustavsson *et al.* (2015) when we employed a similar case, going from six to three pills is a more realistic example. Therefore, I employ the modified example here as well.

Furthermore, the reason why Mary outweighs Margaret may be that she needs a higher level of functioning or that she is worse off than Margaret. This means that the preference involved may affect the actual level as well as the higher level of *Z*. Even though the injury may be exactly the same from a biomedical perspective, it may be worse for Mary since it has more impact on her life than it has on Margaret's, or alternatively, Mary may need a higher level of functioning in order to achieve the same level of *Z* as Margaret. This line of reasoning suggests that *the difference criterion* should be modified in order to incorporate the subjective component in *Z*.

The individuated difference criterion. *X*'s condition is such that there is a difference between *X*'s actual *individuated* (current or risk-related) level of *Z* and some higher *individuated* level of *Z*.

Paper II distinguishes between two ways in which a need may be objective: "... (1) the relation *R* between the object *Y* and the goal component *Z* is independent of the person's beliefs about *R*, (2) the goal component *Z* is something valuable for a person independent of his or her attitudes towards a given *Z*...".

The above line of reasoning suggests that a plausible characterisation of health care need accepts the former but rejects the latter as a necessary condition. Hence, in the three-place structure, where *X* needs *Y* in order to achieve *Z*, needs are objective in virtue of the relation *R*, between *Y* and *Z*, being objective. The objectivity of *R* also explains in virtue of what a need for *Y* is a need for *Y* rather than a desire for *Y*. It follows that if a patient's preference partially constitutes a patient's need, it partially constitutes *Z* rather than being directed towards *Y*. To say that preferences may *partly* constitute needs rules out the implausible view that a patient can have a need-based claim on just anything.⁴⁵ Thus, while preferences may partly constitute *Z* they cannot plausibly exhaust *Z*.

This in no way excludes the possibility that a patient may have preferences regarding *Y*. However, if so, these preferences do not qualify as constituents of his or her need, but are preferences that should be respected for reasons stemming from considerations of

⁴⁵ To pinpoint more precisely to what extent a patient's preferences should matter for decisions about their care is a complex task. However, the concept of "window of compromise" mentioned in paper II and discussed by Sandman & Munthe (2009) may provide some guidance to this question.

autonomy. It makes sense to say that John (discussed in paper II), a Jehovah's Witness who refuses a blood transfusion because of his religious beliefs, still needs a blood transfusion in order to survive.

The case of John also suggests that while health care professionals, normally, have a certain expertise as regards different Y s as well as the causal relation R between a given Y and a given Z it may be that the patient has a special expertise regarding Z (and in some cases, like the case of John, also a special expertise regarding R). In a more general sense, then, professionals are not experts on what kind of life the patient wants to lead; in this sense the patient has a certain epistemological privilege on Z .⁴⁶

As the *individuated difference criterion* does not say anything about X 's attitudes towards, or beliefs about Y , a distinction can be drawn between on the one hand a distribution according to need with the *individuated difference criterion*, and on the other hand, a distribution based on mere demand. A distribution according to demand says that if X has a preference for Y , and demands Y , this is a reason why X ought to be given Y . Accordingly, while a distribution according to need with the *individuated difference criterion* is objective in sense (1), a distribution according to demand is not.

Before I move on to characterising the next condition of adequacy I shall make a brief comment on dispositional needs, needs that do not entail lack. For example, it is true for most people that they need water in this dispositional sense even when drinking some. In paper I, I argue that since these needs are, what Thomson (1987; 2005) refers to as, non-circumstantial, they are irrelevant for understanding needs for health care. That dispositional needs are non-circumstantial entails that whether X needs Y or not does not depend on the particular situation but is something that X carries around from one situation to another. However, this feature squares badly with the constant development of new medical interventions. Health care needs just do not seem to be non-circumstantial in the sense suggested by Thomson.

However, this does not exclude that there is a dispositional sense of need embedded in ordinary language according to which needs do not imply lack. In paper I, when I claim that a need for Y implies the lack of Y , I refer to the claim that one cannot need what one already has. For example, if Adam has a wheelchair and he needs that

⁴⁶ A further complicating factor here is that the epistemological privilege need not accrue to the patient. For example, in cases of impairments of psychological functions it may be that someone else (such as a friend or a partner) is in a better position to make these judgements.

wheelchair, he cannot also have a need-based claim on another wheelchair.⁴⁷ Thus, Adam may correctly claim that he needs his wheelchair while referring to the one he already has.⁴⁸ Thus, when I conclude, in paper I, that dispositional needs seem “...irrelevant to the project of constructing a theory of health care need...” I refer to the conclusion that *Thomson’s* construction of dispositional needs is irrelevant for constructing *health care* needs as they are non-circumstantial.

The Concept of Health Care Needs – *the benefit criterion*

The difference criterion suggests that *X* has a need when there is a difference between two different levels of *Z*. But how should the relation between *Y* and *Z* be understood more specifically? In paper I, I argue that the analysis according to which *Y* is a necessary condition for achieving *Z* is unsatisfactory for analysing needs for *health care*. However, as regards needs in general one may well be a pluralist regarding the relation between *Y* and *Z*. This means that some needs are best understood as *Y* being a necessary condition for achieving some *Z*. For example, oxygen is necessary for me in order to survive. However, other needs may be better understood in terms of *Y* being potentially beneficial for *X* in order to achieve *Z*, and more importantly, when moving from needs to health care needs, the necessity analysis should be abandoned in favour of making sense of this relation in terms of *the benefit criterion*.

The benefit criterion. There is a competence *C* and an intervention *Y* such that, *C* and *Y* can be rationally employed by health care in order to benefit *X* in order to, to some extent, achieve the higher level of *Z*.

Whereas *the difference criterion* explains in virtue of what it is bad for someone to have unsatisfied health care needs (and thereby appeals to *the value condition*) *the benefit criterion* accounts for the relation between health care and the goal of health care, between *Y* and *Z*. In order for *the benefit criterion* to be fulfilled, health care must be

⁴⁷ Assuming that the second wheelchair is like the one he already has in all relevant respects and that Adam does not need two wheelchairs.

⁴⁸ Thanks to Lennart Nordenfelt for convincing me about this point

able to reduce the difference in Z, to some extent. That is, if there is a health care need, health care can benefit the patient. Thus, *the benefit criterion* follows quite naturally from the consequentialistic logic of needs according to which one cannot need what one would not benefit from, at least to some degree and with some likelihood. For example, it makes no sense to say that I need an insulin shot if I would not benefit from it.

From the above, it may be concluded that the conjunction of *the difference criterion* and *the benefit criterion* explains in virtue of what X may have a claim on health care resources. This is the sense in which needs for health care may provide moral reasons for acting, i.e. reasons for providing health care.⁴⁹

Let me now elaborate on the dimension of rationality in *the benefit criterion*. As in the case with objectivity discussed above, rationality may also be discussed with respect to the object Y and/or the goal Z.⁵⁰ For example, one may suggest that an action is rational if it maximises the agent's expected utility. This is to refer to a goal as being rational.⁵¹ This is not the claim I want to make by referring to rationality. Rather, I want to refer to instrumental rationality, which involves the idea that given a goal Z, it is more rational to achieve Z by employing Y rather than Y* if Y is more efficient in order to achieve Z. Accordingly, the appeal to rationality is intended to refer to the fraction of people's well-being that may be raised by health care. That is, given what health care can do, it may be more or less rational to satisfy a particular need within health care rather than in some other domain in society.⁵²

Strengthening the Appeal of the Benefit Criterion

Before I elaborate on the advantages of *the benefit criterion* I shall clarify a potential confusion. One may wonder to what extent health care should be able to benefit X for this benefit to partly constitute a need for health care. I cannot see that the *concept of need* would be better constructed with such a requirement. It is enough to require some (a minimal) level of benefit as well as some (a minimal) degree of probability of benefit

⁴⁹ See Broome (1999, ch. 7) where he discusses how claims and reasons are related. He also mentions the idea that needs may generate a claim on resources.

⁵⁰ For an in-depth discussion about rationality see Parfit (2011, ch. 5).

⁵¹ While some philosophers have claimed that only means can be governed by reason and ends cannot (as famously argued by David Hume) others claim the opposite (see again Parfit 2011, ch. 5).

⁵² This is sometimes framed in terms of the domain of health care (see e.g. Liss 1996).

for a health care need to arise. This is just to say that there is a need for health care, however. It says nothing about the strength of one's need-based claim. With this clarification I shall move on to discuss the benefits of *the benefit criterion*.

First, many treatments benefit only a proportion of the patients suffering from the condition which is targeted by the treatment. Therefore, it is difficult to say in advance whether a given patient will benefit from a given treatment, and if so to what extent. A plausible concept of health care need should capture this probabilistic nature of prognosis essential to medical treatments. The move from necessity to *the benefit criterion* better accounts for this. So when writers like Liss (1993) and Daniels (1995) say that health care should be *necessary* for reaching the goal of need they overlook the fact that medical treatments do not, normally, have such a strong relation to the goal component. Hence, *the benefit criterion* squares better with the nature of medical treatment and (competent and informed) discussions about medical matters. In this sense *the benefit criterion* appeals to *the ordinary language condition*.

Second, a more fundamental question here would be what these writers are referring to when they make use of the notion of necessity. For example, Per-Erik Liss says that necessity may be specified in terms of notions such as indispensability and irreplaceability in the sense that, in the three-place structure, "...*nothing* can take the place of *Y* with *Z* as a result..." (my italics. Liss 1993, p. 53). Once again, this idea seems too strict. There may be ways to achieve *Z* outside health care practices, and even when this is the case, it makes sense to consider a certain need a need for health care.

For example, consider Jack, who suffers from social anxiety and experiences severe symptoms in some specific situations. Recently, Jack discovered that these symptoms can be significantly reduced if he takes three shots of vodka prior to entering these situations. Jack's physician suggests that Jack needs to be on anti-depressants for a period of time in order to get rid of these symptoms. Jack replies that it is not the case that he *needs* anti-depressants in order to reduce his symptoms since such a judgement would presuppose that there is *nothing else* other than anti-depressants that can reduce his symptoms. But there is: three shots of vodka.

If the goal is to get rid of symptoms in specific situations it seems as if it makes perfect sense to say that Jack needs anti-depressants *even though* there are other options, such as, in this case, three shots of vodka. The move from necessity to ability can account for these kinds of situations.

Third, *the benefit criterion* has the resources to account for the moral force deriving from needs where there are currently no treatments available. That is, the concept of health care need should not be constructed in a way that presupposes that if there is no intervention there is no moral claim. I shall skip past this point quickly as it is elaborated on in paper I. However, before I move on to discuss further benefits of *the benefit criterion*, let me clarify one aspect of this criterion discussed in paper I.

I claim that *the benefit criterion* can be refined in order to account for the moral weight of needs for which there are no interventions. This moral weight may be accounted for, for example, by doing research in order to come up with a treatment for, say, a kind of cancer for which there is currently no treatment. However, it may be objected that there is *always* an intervention for all conditions. If a patient has a cancerous tumour that causes great pain, but there is no treatment for that cancer, there is another intervention, namely the reduction of pain. But this is not the point I want to make. When I say that there is no intervention I mean to refer to the causal relation in the sense that there is no intervention that removes or reduces the size of the tumour.

Fourth, *the benefit criterion* is a simpliciter in the sense that makes the reference to lack superfluous as it accounts for this feature of need. It seems sufficient to say that if *X* cannot benefit from *Y* then *X* does not need *Y*. I cannot see that one *also* has to refer to the notion of lack. In writing paper I, I did not quite realise this.

Objections to the Proposed Definition

In order to state the objections as clearly as possible let me put them in terms of the conditions of adequacy for conceptual analysis outlined in the methodology chapter.

First, let me start with *the simplicity condition*. Hitherto, the discussion suggests that the notion of health care need may be plausibly understood in terms of the following two criteria: *the difference criterion* and *the benefit criterion*. As this characterisation is constituted by a conjunction of two criteria one may argue that such a construction squares badly with *the simplicity condition*. It seems to me, however, that simplicity should not be given too much weight here. Whereas simplicity, all else being equal, makes concepts better as when so constructed they are easier to handle it may come with an inability to capture complexities. As the nature of this project as a whole suggests, its subject matter has quite a high degree of complexity. Therefore, it is not a

serious problem that the concept outlined here is constituted by two criteria rather than one criterion.

Second, one may object to the proposed definition, referring to the urge for precision prescribed by *the precision condition*, by saying that it is too vague. It may be questioned to what extent one could arrive at a precise definition of health care, and even if one could, to what extent would such a precision be desirable? It seems right to say that *the precision condition*, all else being equal, is a desirable feature of a definition. However, in the present context *the precision condition* has to be weighed against a *condition of normative adequacy* which prescribes that a well-constructed definition of health care need should be flexible enough to allow for the formulation of different versions of principles of need. That is, the concept of need should not exclude substantial normative ideas about how resources should be prioritised among needs. Hence, increased precision should not be bought at the price of excluding normative positions. For example, the *concept* of need should not decide the normative question of whether indirect benefits of health care interventions should be taken into account when their efficiency is assessed (see e.g. Brock 2003). Likewise, as the concept of need should allow for different formulations of a principle of need, it should not determine the strength of such claims. Hence, while the concept of need may identify moral dimensions that are plausible candidates for carrying moral weight, it has no implications for the weight that should be ascribed to these different dimensions.

Moreover, people tend to change their intuitions over time about what states should be taken to be needs for health care. To a large extent this seems dependent on what conditions there are treatments for. For example, shortness was not really considered something indicating a need for health care before growth hormones were introduced onto the medical market. A definition of health care need should be flexible enough to capture such changes.

Needs as a Distributive Principle

In this section, I shall, drawing on the conceptual discussion undertaken in the previous two sections, discuss a number of conditions of adequacy that a plausible principle of need should fulfil. It seems clear that for a distributive principle to qualify as a need principle it has to ascribe *some substantial* moral weight to the worse off. That is,

additional weight to whatever favourable by-product may be implied by the thesis of diminishing margin utility or assumed by other principles such as the thesis that the worse off may be easier to help. I shall refer to this condition as:

The priority to the worse off condition (i). A principle of need ascribes some substantial moral weight to the worse off.

To give priority to the worse off is an essential feature of a principle of need. For a principle to qualify as a need principle it should satisfy this condition. Let me further distinguish between weak and strong versions of *the priority to the worse off condition*

A weak interpretation of this condition would say that, all else being equal, benefits accruing to the worse off matter more. For example, if Jack is at health level 0.2 and Jill is at level 0.5, and they can both be benefited by 0.3 units of health, Jack should outweigh Jill as he is worse off. Note that the principle of cost-effectiveness stated by itself would be indifferent between these two options, on the assumption that the costs are the same (this will be assumed in the following).

In order to state the strong interpretation of *the priority to worse off condition* let us remove the all else being equal clause: benefits accruing to the worse off matter more, period. In the Jack and Jill scenario, the strong interpretation would imply that Jack outweighs Jill even if his treatment demanded more resources. Note that the principle of cost-effectiveness stated by itself implies the opposite course of action in such a case.

As regards these two interpretations, I believe, even if I shall not argue for it here, that the weight that the weak interpretation ascribes to *the priority to worse off condition* seems too weak and the weight that the strong interpretation ascribes seems too strong. Hence, a plausible characterisation of a principle of need should ascribe a weight to *the priority to worse off condition* that falls somewhere in between the weak and the strong interpretation. This means that whereas principles of need imply that decision-makers should be prepared to spend more resources on benefits that accrue to people who are worse off it remains to be further specified precisely how much more.

In paper IV, I distinguish between being worse off in a condition-specific sense and in a holistic sense. According to the condition-specific sense a patient is worse off to the extent the patient is worse off with respect to the condition that is targeted by the relevant intervention. According to the holistic sense a patient is worse off to the extent that the patient is worse off when all of the patient's conditions are considered. Paper IV

further argues that the condition-specific account lacks moral justification and results in counterintuitive outcomes. In this vein, it may be appropriate to further specify *the priority to the worse off condition* in the following way:

The priority to the worse off condition (ii). A principle of need ascribes substantial moral weight to the worse off in terms of holistic severity.

Consider an objection to the conclusion that severity should be understood as holistic severity. On the one hand it seems as if when a person has two conditions, *A* and *B*, and we are prioritising among treatments that target *A*, we should also consider the severity of *B*. This is compatible with *B* being untreated which means that the severity of *B* is, simply, taken into account as it is. It is also compatible with *B* being partly treated which means (most reasonably) that the severity of *B* is taken into account to the extent *B* makes the person worse off when treated. This follows from the holistic account. However, it is also true, in some sense, that the patient has already been given, or will be given, treatment for *B*, elsewhere in the system. Thus, the severity of *B* has already been, or will be, accounted for. So, why should the severity of *B* be accounted for again? The reason is the following. The severity of *B* is only relevant for prioritising treatments that target *A* as long as *B* makes the patient worse off than the patient could have been, with or without treatment.

The priority to the worse off condition denotes one part of what constitutes a need-based claim. In order to have a need-based claim on health care resources one should not only be worse off, it should also be possible to satisfy the health care need to some extent. That means that the patient must have some capacity to benefit from treatment.

The capacity to benefit condition. A principle of need ascribes importance to the degree to which a patient can benefit from treatment.

This condition may be argued for on conceptual as well as normative grounds. Let me start with a conceptual argument. *The benefit criterion* for *the concept* of health care need says that one cannot need what one cannot benefit from. Hence, a *principle of need* constructed without capturing this consequentialistic logic of needs would be less easy to recognise as a need principle. It would not capture the essential feature of ideas about needs, namely that satisfying needs means accruing benefits.

Consider next a normative argument for *the capacity to benefit condition*. A principle of need should not only be recognisable as a principle of need, it should also be as reasonable as possible from the point of view of distributive justice. For example, a principle of need that ascribes absolute priority to the worst off and is constructed without *the capacity to benefit condition* may imply counterintuitive outcomes. Consider, for instance, the bottomless pit objection: that it is unreasonable to distribute all resources on a small number of (very needy) patients, especially since almost as needy patients may be helped a lot more for the same resources (see e.g. Brock 2002). Hence, whereas a reasonable need principle gives substantial weight to the worse off, it does not involve an *absolute* priority to the *worst* off.

How should the trade-off between *the priority to the worse off condition* and *the capacity to benefit condition* play out? Suppose Jack is at health level 0.2 and there is a treatment *A* that can raise him to 0.5, but there is also another treatment *B* that can raise him to 1. A plausible principle of need should imply that Jack has a stronger need-based claim on *B* than he has on *A*. Hence, as with *the priority to the worse off condition* *the capacity to benefit condition* may be interpreted in a weak and a strong sense. A weak interpretation of *the capacity to benefit condition* may be formulated in the following way: all else being equal, to satisfy a given need *N* more is better than to satisfy *N* (or some other need) less. This means that if Jack and Jill are both at health level 0.2, and Jack can be raised to 0.5, whereas Jill can be raised to 1, Jill outweighs Jack as more need satisfaction accrues to her. Hence, all else being equal, greater need satisfaction outweigh smaller need satisfaction.

This is to ascribe a very limited role for benefits in a need principle. Are principles of need plausibly characterised with a strong benefit condition? Let us remove the all else being equal clause and state the strong version of *the capacity to benefit condition*: to satisfy a given need *N* more is better than to satisfy *N* (or some other need) less. This would be to understand needs only in terms of capacity to benefit. This would be to ascribe weight to benefits in the same way as the principle of cost-effectiveness does. If Jack is at 0.2 and Jill is at 0.6 and Jack can be raised to 0.6 and Jill can be raised to 1, a principle of need satisfying the strong benefit condition would be indifferent to whether Jack or Jill is treated. However, this would be to violate the weak version of *the priority to the worse off condition*. Hence, a principle of need cannot be plausibly characterised as capacity to benefit.

However, the issue of trade-offs between *the priority to the worse off condition* and *the capacity to benefit condition* is more complex than that. Therefore, it requires a more nuanced analysis. One of the crucial questions to answer regarding need principles is how these principles should handle questions about the aggregation of benefits across individuals. Paper III attempts to strike the right balance between *the priority to the worse off condition* and *the capacity to benefit condition*. DTP is constituted by a prioritarian element and elements of sufficiency. Prioritarianism is applied from 0 to 1, and accordingly it matters more to benefit people the worse off these people are. It is then further argued that the prioritarian principle combined with unrestricted aggregation would not give enough weight to *the priority to the worse off condition*. In order to handle this issue, DTP applies two thresholds in order to constrain what trade-offs are allowed, for example, one at 0.2 and one at 0.8. These thresholds categorise people into three groups: the worst off below the lower threshold, the moderately badly off between the thresholds, and the best off above the upper threshold.⁵³ DTP prohibits resources being taken from the worst off in order to benefit the best off. Thus, the following condition may be formulated.

The restrained interpersonal aggregation condition. A need principle is not incompatible with aggregation if it avoids trade-offs from the worst off to the best off.

To say that principles of need have implications with regard to interpersonal aggregation in the way suggested by *the restrained interpersonal aggregation condition* is also to say that it is not the case that a normative theory about priority setting has accounted for the implications of principles of need by adding a weight into principles of cost-effectiveness. *The restrained interpersonal aggregation condition* suggests that principles of need have implications for distribution that go beyond such refinements of principles of cost-effectiveness.

⁵³ In fact, a similar grouping was suggested in Official Norwegian Reports (2014); see also Ottersen *et al.* (2016). However, these groups are used for determining reasonable costs per health benefit in different groups. That is, spending more resources per health benefit in the worse off group(s). However, while this may diminish the frequency with which the best off benefit at the expense of the worst off, such distribution may still be implied if the best off are numerous enough. The purpose of DTP is to avoid such implications.

The discussion hitherto has proposed three conditions which have to be fulfilled for a principle to qualify as a reasonable need principle. DTP fulfils these conditions. Before I conclude this chapter let me consider an objection to DTP.

I have argued that the primary purpose of the concept of need is to constitute a basis on which a principle of need can be constructed. Consider an objection which may be directed towards DTP as a characterisation of a need principle on the grounds that DTP is not in line with conceptual intuitions about needs. This objection was posed by a reviewer to paper III who suggested that the notion of needs has a widely-recognised anti-aggregative ring to it. Let me restructure this criticism in the terminology employed in this thesis. This objection criticises DTP on the grounds that the aggregation of needs does not square well with *the ordinary language condition*. There is a conceptual intuition that says that needs cannot be aggregated. There might be something to this objection. However, as I have stressed in the methodological discussion, *the ordinary language condition* is *one* out of several conditions of adequacy. Therefore, it has to be weighed against other conditions, and the best weighing is determined by the purpose of the concept. I have argued that an important purpose of the notion of health care need is to serve as a basis on which a plausible principle of need can be characterised. Therefore, it seems plausible to appeal to *a condition of normative adequacy* according to which a concept of need should not rule out the possibility to construe normative plausible ways to handle aggregations. Moreover, the best principle of need is not *only* determined by features of the concept of need. It has also to be reasonable from a normative point of view. DTP strikes the right balance between *the ordinary language condition* and *a condition of normative adequacy*.

Conclusions

In order to sum up the concluding discussion this section provides a list of the main conclusions to be drawn from this thesis.

(i) As opposed to conceptual analysis of needs in the general philosophical discussion, health care needs should not be understood as *Y* being a necessary condition for *X* in order to achieve *Z*. The formal structure of health care needs should be constructed in the following way: *X* can be benefited by *Y* in order to achieve *Z*.

(ii) Needs carrying moral weight have traditionally been understood as being objective with regard to their goal component Z. However, this is an implausible characterisation of needs in priority setting. A plausible analysis of Z is, at least, not independent of what the patient wants.

(iii) Needs should not be applied to distribution by ranking them according to their size. A principle of need can be further specified for priority setting as a mid-level moral principle drawing on ideas about distributive justice.

(iv) It is not the case that need principles have to be characterised as being incompatible with interpersonal aggregation. In fact, principles of need may be characterised as allowing for some aggregations while still ascribing absolute priority to the worst off in a limited sense, namely to the worst off over the best off.

(v) The relevant sense in which a patient is worse off is not determined by how badly off he or she is with respect to the condition that is targeted by the relevant treatment (condition-specific severity), but should be understood as how badly off the patient is when all of that patient's conditions are considered (holistic severity).

FURTHER QUESTIONS

In this chapter I shall outline some of the remaining questions that I have not been able to consider, as well as some questions that the conclusions sketched above may have raised.

Health Care Priority Setting as an Academic Field

The field of priority setting is, I believe, a good example of an interdisciplinary academic field. In order to better understand and approach the problems which many health care systems face, a range of disciplines may be useful. The academic field of priority setting has aspects that can be successfully studied by, for example, social scientists, clinicians, health economists, as well as philosophers of medicine and medical ethicists. This does not necessarily mean that the medical ethicist should engage in empirical studies or that health economists have to understand the details of conceptual analysis. It means that the medical ethicist should know enough health economics in order to have an informed discussion, and vice versa.

Consider for example the role of public views on distributive justice in moral reasoning. It is often assumed that societal preferences should play an important role in determining what principles should guide priority setting,⁵⁴ whereas some people make the even stronger claim that these preferences are decisive for determining these questions. In contrast to such ideas, moral philosophers traditionally believe that such preferences have no impact (or only an indirect impact) on what action (or resource allocation) ought to be done. That a certain group of people at a certain time happen to adhere to certain values or principles is, simply, irrelevant for the rightness of these values and principles.

Consider a promising role for societal preferences in moral reasoning. As discussed in the methodology chapter, the process of reflective equilibrium may be extended to a

⁵⁴ I make this claim on the basis of my experience of participating at conferences such as "Examining the Past and Contemplating the Future – 20 Years of Priority Setting", November, 2014, Melbourne, Australia and "New Frontiers in Priority setting", September, 2016, Birmingham, United Kingdom.

wide reflective equilibrium in terms of alternative views. The more relevant alternative views one considers, before one arrives at a given resting point, the more justificatory force that resting point has. Since the moral philosopher cannot, for practical reasons, take all moral opinions into account, Rawls suggests that he or she has to be satisfied with the second best option which is to "...characterize the structures of the predominant conceptions familiar to us from the philosophical tradition, and to work out the further refinements of these that strike us as most promising" (Rawls 1974-75, p. 8). Rawls mentions rather than argues for this source of alternative views.

However, a further possible source of alternative views is studies of public views. Studies of people's moral views may provide the process of reflective equilibrium with alternative views which may be used in order to increase the justificatory force of a given resting point. Studies of people's moral views may provide moral philosophers and ethicists with alternative views found among citizens. To inform the process of reflective equilibrium in this way seems a promising role for empirical research in moral reasoning. However, more work is needed in order to understand what role such studies should play more specifically.

The Goal(s) of Health Care

How the operational and final goal(s) of health care should be characterised more specifically is one of the remaining questions for characterising needs for priority setting. The discussion in this thesis suggests a number of criteria which such a plausible theory should fulfil. For example, these goal(s) cannot reasonably be understood as being independent of what people want and they will concern the person as a whole rather than his or her specific conditions.

Furthermore, in relation to health care priority setting as a field in academia one may ask if this question can be reasonably set, independent of public views on these matters. To be sure, people's normative views on the goals of health care cannot reasonably constitute any right making characteristic of such goals; however, people's normative views should perhaps be taken into account for other reasons. These reasons may be plausibly discussed in relation to the Rawlsian conception of over-lapping consensus, according to which it may be possible to find some values on which people agree, irrespective of what normative doctrine they adhere to more specifically.

The Possibility of Collective Needs

Several of the puzzles discussed in this thesis may be extended from individuals to groups. Some people take needs to be conceptually linked to individuals rather than groups (see e.g. Sheaff 1996). However, it is not entirely clear why one should accept this view. There seem to be several cases where it makes better sense to understand *X* as a collective rather than as an individual. Consider a case of infertility in which there is a couple who cannot become pregnant. The doctor's recommendation is In Vitro Fertilisation (IVF). To say that the woman involved needs treatment in order to become pregnant does not seem to quite capture what is going on. It may make better sense to say that the couple needs IVF *as a couple*. *They* need IVF in order to become pregnant.⁵⁵ Whereas such an example may bring out the conceptual intuition it remains somewhat difficult to account for the moral implications, if any, for priority setting. One way to make sense of this case is to reconsider the assumption, which I have merely touched upon in paper I and paper II, that *X* equals one single individual.

In order to better understand such cases, consider an analogy to moral responsibility. The notion of collective responsibility departs from the observation that sometimes collectives harm some individual or group, be it a company or a government which inflicts harm on people (see e.g. Pettit 2007). If there is no well worked out idea of collective agency and collective responsibility there is a risk that such harm will not be adequately accounted for. If the notion of responsibility is tied to individuals (and not groups) moral judgements, for example about blame, may fail to account for the amount of blame which could have appropriately corresponded to the harm caused by the action.

Now, could one plausibly argue the same way about needs? I believe there is interesting work done on collective agency (and perhaps collective responsibility) to build on in order to make progress around these questions. Furthermore, if one opens this door it is difficult to see why one could not construct larger agents that need treatment, such as vaccination programmes, where a population may be the carrier of a need-based claim.

⁵⁵ Note that the WHO defines infertility (in cases where couples are involved) as a condition that accrues to the couple rather than the individuals involved: "Infertility is the inability of a sexually active, non-contracepting *couple* to achieve pregnancy in one year" (my italics, see WHO 2017).

If collective agents are plausible candidates for carrying need-based claims the reasoning in this paper will be affected in several important respects. For example, in relation to paper II, it seems that the models of shared decision-making developed by Sandman & Munthe (2009) to which I refer need to be developed. In paper II, I claim that "...there are two sides to consider with regard to the decision. First there is the professional's view of what treatment would be in the patient's best interest, second there is the patient's own view of this." This claim would still be true even if there were collective agents; however, one of these sides would then be a collective which, arguably, makes the model more complex.

The increased complexity of collective agents may be further exemplified in relation to paper IV. It seems that if there are different ways in which more than one condition may interact within one individual, these relations will increase in terms of complexity as more than one condition may interact within a collective between individuals. This is not only important in order to understand how these relations interplay but also poses difficult questions about the moral relevance of these relations.

Trade-Offs and Need-Based Claims

Any plausible characterisation of a principle of need will be a part of a normative theory about how priority setting ought to be done. Whereas I shall not argue for such a full blown theory here, I shall point to a number of considerations that I believe a principle of need will be weighed against. First, there is a trade-off between the two conditions within a need principle. That is, *the priority to the worse off condition* has to be weighed against *the capacity to benefit condition*. How much more does it matter to benefit people who are worse off?

Second, priority setting cannot be reasonably done without considering the cost of treatments. This is, in my view, primarily for ethical reasons, the opportunity cost should be considered. That is, what *could have been done* for the resource just spent. This means that a principle of need should be balanced against a principle of cost-effectiveness. As I have characterised a principle of need as partly constituted by how much a patient can benefit from a treatment, this may pose questions about double counting benefits that accrue to a patient if one considers benefits as part of cost-effectiveness as well as part of a principle of need. However, how the reference to double counting should be understood more specifically remains somewhat unclear. For

example, that there are two different reasons for a given allocation of a resource is not double counting.

Third, as mentioned in the background chapter, most countries that have official guidelines for priority setting include some concern for formal equality. In Sweden this principle is referred to as the principle of human dignity. I described this principle in the background as saying that morally irrelevant factors such as age and gender should not affect one's ranking in priority setting. One way in which such a principle may have implications for priority setting is that although it may be associated with a higher cost to detect myocardial infarction in women than in men, decision-makers should be prepared to accept a higher cost for the diagnostic measure for women than for men (see Sandman & Gustavsson 2017). However, this consideration has nothing to do with principles of need; this is motivated by a principle of formal equality. Hence, formal equality cannot plausibly be thought of as an "all or nothing affair" since it has to be weighed against other considerations. This means that one's need-based claims on health care resources may have to be weighed against one's claims based on formal equality. However, how to understand this trade-off more specifically has to be further analysed.

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Papers

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