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Disentangling the welfarism/extra-welfarism distinction: Towards a more fine-grained categorization

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Abstract

In health economics, the distinction between welfarism and extra-welfarism has been employed to discuss various epistemological and normative differences between health evaluation approaches. However, a clear consensus on the definition of either welfarism, extra-welfarism, or the differences between the two sets of approaches has not emerged. I propose an alternative set of distinctions that allows for a more fine-grained categorization of health evaluation approaches. This categorization focuses on five dimensions: (1) the maximand of an evaluation approach, (2) its sensitivity toward normative concerns that defy compensation, (3) its position on which groups of individuals or collective entities act as sources of values, (4) its sensitivity to changes of mind, and (5) the inclusion of process-external values.

KEYWORDS

deliberative democracy, ethics, philosophy of health economics, political philosophy

1 | INTRODUCTION

In health economics, the distinction between welfarism and extra-welfarism categorizes economic health evaluation approaches at the population level into two different camps (Coast et al., 2017). Welfarism refers to evaluation approaches focused on maximizing individual utility whereas extra-welfarism is described as an alternative transcending this focus. Within the literature, several accounts exist—each defining welfarism, extra-welfarism, and their differences in a different and sometimes conflicting manner. This lack of a clear definition of the welfarism/extra-welfarism (W/EW) distinction means that the concepts are less useful than they could be for categorizing differences between health evaluation approaches. I argue that it is often better to address these differences with terminology that is geared toward this specific purpose. To this end, I provide a brief overview over various W/EW distinctions, review their usefulness for cartographing the landscape of health evaluation, and present a more fine-grained set of categorizations that serves to address the differences between health economic evaluation approaches head-on.

2 | WELFARISM VS. EXTRA-WELFARISM: DIFFERING DEFINITIONS

One of the few commonalities of the varying W/EW distinctions in the literature is that they characterize welfarism in health economics as an evaluation approach focused on the maximization of individual utility. Various accounts exist as to how utility is understood and measured within a welfarist scope, but most focus on the evaluation of individual preferences expressed in monetary terms (see Razzouk, 2017). Extra-welfarism possesses no independent definition but is defined in contrast to welfarism as a cluster of approaches that go beyond its focus on individual utility (Birch & Donaldson, 2003; Coast et al., 2017; Seixas, 2017). How precisely extra-welfarist approaches transcend the welfarist scope differs between accounts and a clear consensus on the definitions of either welfarism, extra-welfarism, or of the distinction between the two sets of approaches has not emerged.

In the first description of an extra-welfarist approach within health economics I have been able to identify, Culyer (1989) contrasts extra-welfarism with an understanding of welfarism that is defined as being exclusively concerned with the utility individuals derive “from goods and services (including labor services)” (1989). Notably, this understanding of welfarism excludes the evaluation of what Culyer calls “non-goods characteristics of individuals” (1989), such as their happiness, freedom of choice, and more. Culyer argues that extra-welfarism transcends this narrow evaluation space of welfarist approaches by incorporating Sen’s capability approach (Sen, 1992) into the set of relevant criteria for the normative value of health, including such capabilities as “being able to move about, to lead a healthy life, to take part in the life of the community” (1992, p. 82).

Later attempts to define the W/EW distinction focused on different aspects of health evaluation. Birch and Donaldson (2003) suggest that extra-welfarism goes beyond welfarism’s focus on individual utility and draw attention to Mooney’s approach to focus on the collective values of communities as an example of extra-welfarist health economics (Mooney, 1998, 2000). A closely related but distinct argument is the idea that extra-welfarism transcends the welfarist assumption that individuals are the best judges of their own utility (Birch & Donaldson, 2003; Coast et al., 2008). Extra-welfarist approaches have also been described as transcending consequentialist normative frameworks (Birch & Donaldson, 2003; Brouwer et al., 2008). Other accounts (e.g., Hurley, 1998; Seixas, 2017) draw yet other distinctions and propose that extra-welfarists replace the welfarist concept of utility maximization with health maximization. Notably, this contrasts with the accounts reviewed above that propose that extra-welfarism is sensitive to values that are not directly health-related, such as capabilities or community values. As Razzouk notes: the “distinction is far from being simple and free of divergent views and conceptualizations among health economists” (2017, p. 36).

3 | TOWARDS A MORE FINE-GRAINED CATEGORIZATION SCHEME

The positions reviewed above point to important differences in how different evaluation approaches conceptualize the value of health. However, a clear consensus on the definitions of welfarism, extra-welfarism, or of the differences between the two set of approaches has not emerged. It would hence be more productive to use categorizations that spell out these differences directly. A sketch of such a set of categorization follows.

3.1 | Consequentialism and compensation

Culyer’s (1989) critique of the narrow focus of welfarist approaches on goods utility has led to the incorporation of health states and indicators of process utility into most contemporary evaluation approaches (Ryan et al., 2014). As evaluation approaches exclusively focused on goods utility have fallen largely out of use, Culyer’s definition of the W/EW distinction has become less useful to cartograph the landscape of health evaluation. A related and more recent W/EW distinction is based on the claim that extra-welfarist approaches transcend consequentialist normative frameworks (see Birch & Donaldson, 2003; Brouwer et al., 2008). While this argument has mainly focused on the role of process utility, the concept can be expanded by making use of a broader understanding of consequentialism.

Broadly speaking, consequentialist theories consist of two parts: an *ordering principle* based on outcomes, usually maximization (or sufficiency, maximin, Pareto optimization, etc.); and a *maximand*, that outcome which is to be maximized (or Pareto-optimized, etc., see Brown [2011]). From this, we can derive two axes of categorization: (1) evaluation approaches that focus on different maximanda and (2) approaches that do or do not conform to consequentialist ordering

principles. A third option, based on differing ordering principles, does not strike me as relevant for the health economic context.

As Brouwer et al. (2008) point out, claims that extra-welfarist approaches transcend consequentialism understand consequentialism as a focus on goods-utility as the (only) relevant maximand and assign the label “extra-welfarist” to approaches that incorporate additional criteria such as process utility. But these approaches do not escape the consequentialist ordering framework, they merely broaden the definition of the maximand. Rather than attaching the welfarist label to approaches using specific maximanda, it might be more fruitful to use multiple categories to describe which approaches focus on which maximand. Ryan et al. (2014) represents a good example of such a categorization.

To identify approaches that defy the broader definition of consequentialism, we must focus on evaluation criteria that cannot be ranked according to consequentialist ordering principles. Consequentialist rankings usually rely on a compensation mechanism to resolve conflicts between the preferences of moral agents (Hicks, 1939). However, some philosophers believe that there are some norm violations that can never fully be compensated for (e.g., human rights) or that there are different types of normative goods that fall into entirely distinct categories and are incomparable in principle (Nagel, 1979, 2008). Both positions indicate that there are moral principles whose violation cannot adequately be compensated for in other areas, either because these principles are inviolable or because they exist in different normative spheres. It makes sense to categorize health evaluation approaches according to whether they are sensitive to such considerations. Some stated preference approaches that allow respondents to select opt-out options (and hence register their refusal to engage in trade-offs) constitute good examples (Campbell & Erdem, 2019).

3.2 | Individual and collective sources of value

Brouwer et al. (2008) identify the presence of “sources of valuation other than the affected individuals” (2008) as a key feature of extra-welfarism. In their discussion, they focus on normative considerations that go beyond the simple aggregation of individual utility such as “quality of utility, equity weights, characteristics and capabilities” (2008). While this distinction brings attention to a range of values not immediately connected to the self-evaluation of an individual's utility, it discusses *objects of normative concern* rather than different *sources of normativity*, that is, the entity from which value judgments emanate. To illustrate the difference, most people regard children as worthy *objects* of normative concern but few would deem their value judgments binding.

The range of *objects* of normative concern included in an evaluation approach says little about its stance on the individual as the exclusive *source* of values. The same applies to differing views on *which* individuals are best suited to supply values. Most evaluation approaches in health economics rest on the assumption that the authorship of values is the exclusive domain of the individual (Jan, 2014). This contrasts with conceptions that see values primarily as an emergent property of social interaction (Gutmann, 1992). Here, the expression of preferences is seen as a social act by communities of people who are engaged in a collective endeavor rather than a solitary action by disconnected individuals (Mooney, 2005).

In addition to differentiating evaluation approaches by their objects of normative concern and the people they deem suited to evaluate them, it is therefore crucial to also differentiate between individualist and collectivist approaches of health evaluation. Deliberative approaches that elicit health preferences from groups of people rather than aggregate individual preferences constitute a good example for the latter (Degeling et al., 2015).

3.3 | Changes of mind and process-external values

The idea that extra-welfarism transcends the notion that individuals are the best judges of their own utility can be read in several ways, depending on which part of the claim one focuses. The focus on “utility” and the focus on “individuals” (understood as a position on the locus of moral agency) have been discussed above. In the following, I will focus on “best judges” as the salient part of the claim. This can take on two related but distinct meanings. First, that individuals are unreliable sources for their preferences because they are not clear about what they want, or because they hold conflicting, inconsistent, or changing views. The second claim is that individuals do not always prefer what is best for them.

In addressing the first claim, economists have often conceptualized the expression of conflicting preferences by the same individual as a symptom of their unreliability (Janssen et al., 2017). As most health economists paradigmatically treat preferences as set and stable (San Miguel et al., 2002), less attention has been paid to changes of mind as a cause

for conflicting responses. It would be useful to classify evaluation approaches by their ability to identify these changes of mind. Mixed-methods approaches that collect qualitative data on the reasons for respondents' (changing) preferences represent a promising development in this regard (Etkind et al., 2020).

The second claim that individuals do not always prefer what is best for them relies on values that are independent from the outcome of evaluation procedures. If what is best for the individual is defined by health outcomes such as longevity, relapse probability, etc., the judgment of individuals might indeed trail the judgment of health professionals in terms of effectiveness. However, this assessment relies on a value judgment about good health that is reached independently from the views of the affected. From the perspective of normative theory, it would help to address this distinction in terms of a focus on process-internal or process-external values (Rawls, 1999). Stated preference approaches and health self-assessments are examples of the former, health outcome measures of the latter.

4 | CONCLUSION

While the W/EW distinction has raised important issues relevant to how we conceptualize the field's normative and epistemological landscape, the way these issues are framed is not always helpful. The distinction can refer to a number of dimensions in which approaches toward health evaluation can differ. As these are independent dimensions, it often makes sense to replace the coarse-grained W/EW dichotomy with a more precise description of the relevant differences.

I identified five dimensions that I believe are easier discussed on their own terms: (1) the maximand of an evaluation approach, (2) its sensitivity toward normative concerns that defy compensation, (3) its position on which groups of individuals or collective entities act as sources of values, (4) its sensitivity to changes of mind, and (5) the inclusion of process-external values. This is not an exhaustive list of distinctions that can be drawn between different approaches. But it contains the most relevant differences between conceptualizations of health and healthcare evaluation that have been discussed under the umbrella of the W/EW distinction. This discussion has been an important one. Health economists can push it forward by using more precise distinctions that capture the relevant differences more accurately.

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CONFLICT OF INTEREST

The author declares no conflicts of interest.

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