

A conversation with Professor S. Andrew Schroeder, September 13, 2016

Participants

- Professor S. Andrew Schroeder – Assistant Professor of Philosophy, Claremont McKenna College
- Josh Rosenberg – Senior Research Analyst, GiveWell

Note: These notes were compiled by GiveWell and give an overview of the major points made by Professor S. Andrew Schroeder.

Summary

GiveWell spoke with Professor Schroeder of Claremont McKenna College about moral tradeoffs in cost-effectiveness analyses. Conversation topics included ways to reflect the values of different populations in cost-effectiveness analyses, moral tradeoff discussions in academia, and suggested methods for improving GiveWell's cost-effectiveness model.

Reflecting different sets of values in cost-effectiveness analyses

Professor Schroeder believes that there are no objective answers to challenging questions about moral tradeoffs, such as whether it is more valuable to save one under-5-year-old's life or double five individuals' income for 20 years. For this reason, when creating a cost-effectiveness model that compares interventions with different life-saving or life-improving outcomes, he believes that the best approach is to:

1. Determine whose ethical values should be incorporated into the model.
2. Gather input from the relevant population(s).

An additional factor to consider is the quality of the decision-making process of people making these judgments. It seems valuable to ensure that the people making these judgments are well informed and demonstrate a sincere, reflective deliberation process.

Deciding whose values should be reflected

For organizations like GiveWell that are influencing the funding decisions of donors, it may be useful to consider: 1) GiveWell staff's values, 2) GiveWell donors' values, and 3) the values of populations that receive support from GiveWell's recommended charities.

Gathering input from different populations

There is a body of academic literature on how different populations value a variety of health-related outcomes. The Global Burden of Disease Study of 2010 (GBD 2010) included a large survey of this kind, and the results revealed a surprising degree of similarity in how populations around the world value different health outcomes.

Even among countries of varying levels of wealth and development, there was a high degree of agreement among respondents. However, other studies (such as “Multiple-informant ranking of the disabling effects of different health conditions in 14 countries” by Ustun et al. and this comment by Jelsma et al. - [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(05\)73538-8/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(05)73538-8/abstract)) have not found a high degree of agreement among respondents on how to value different outcomes.

Lessons from GBD methodology

The methodology used in GBD 2010 differed in a number of ways from the methodology used in the Global Burden of Disease Study of 1996 (GBD 1996), including:

1. **Types of questions asked** – GBD 1996 framed questions in terms of resource allocation – e.g., would you prefer to cure X people of one medical issue or Y people of a different medical issue? There was concern that framing questions in this way made it difficult for people to think about them, especially when comparing health conditions that impact small numbers of people to those that impact large populations. GBD 2010 used a different methodology: it asked respondents a different type of pairwise comparison question – e.g., evaluate two hypothetical people suffering from different health conditions and pick the healthier individual. A disability weight scale was created based on the results of these comparisons.
2. **Population surveyed** – GBD 1996 primarily surveyed health professionals and employees of the World Health Organization. GBD 2010 largely surveyed the general population, going door to door in many countries.
3. **Age-weighting** – GBD 1996 used age-weighting – attaching a different value to health outcomes depending on the age of the recipient – and GBD 2010 did not.
4. **Encouraging reflection on choices** – The GBD 1996 methodology included a discussion step. Participants were encouraged to reflect on the implicit values underlying their choices, discuss with others, and revise their responses. Some respondents changed their answers as a result of this process.

Because of the many differences in methodology between GBD 1996 and GBD 2010, their results are difficult to compare.

The disability paradox

The disability paradox – the finding that individuals with what many consider to be serious disabilities (e.g. deafness, paraplegia) often report surprisingly high levels of well-being – is important to consider when gathering input on the value of health outcomes. (More information available here: <http://philpapers.org/rec/SCHHDA-10>)

One caveat to this finding is that many of the studies of the disability paradox have gathered data on reported well-being from developed countries. Individuals

experiencing health issues in developing countries may have different attitudes about how much these issues affect their lives.

Moral tradeoff discussions in academia

Age-weighting

There is no agreed-upon approach in the scholarly community for answering age-weighting questions. When faced with this type of question – e.g., how the life of a 20-year-old should be valued relative to a newborn – individuals have different ways of coming up with an answer. Some would start with a fixed criterion, like life-years or economic impact. They would base their recommendation on what best optimizes for that criterion.

If he were personally deciding his views on age-weighting, Professor Schroeder would likely want to consider a broad range of factors, such as whether individuals of a certain age have personal relationships and desires for the future, and what the expected quality of life is for the different populations.

Relevant research

There are a number of scholars writing on health and ethics issues who have discussed age-weighting in their work, including:

1. **Professor Aki Tsuchiya** – wrote a survey article that compares the different perspectives of those in the field.
2. **Professor John Harris** – proposed the “fair innings” argument – i.e., that everyone’s lives should have equal value until they reach a threshold of having lived a “reasonable life” (e.g., when they are roughly 70 years old).
3. **Professor Greg Bognar**
4. **Professor Dean Jamison** – in a chapter in the second edition of *Disease Control Priorities in Developing Countries*, Professor Jamison argues that fetal deaths and stillbirths should be treated continuously with early infant deaths. So, a fetus that dies late in the third trimester should be given a similar weight to an infant that dies in its first day of life. This is counter to the approach of many other health models.

General philosophy work in this area

Philosophers writing on the value of life can roughly be categorized into a few major schools of philosophical thought, including utilitarianism, contractualism, and Kantianism. These viewpoints could yield implicit judgments for how to weigh different health outcomes for different populations, but there is no centralized discussion of this topic in the field. Philosophers do not typically discuss explicit quantitative moral tradeoffs in their work.

Role of global health scholars in setting age-weighting policy

Professor Schroeder believes that global health scholars typically do not incorporate age-weighting or adjustments for other ethically-important factors into their

estimates of, e.g., the global burden of disease, because they do not see it as their role to make ethical judgments. So, he would not interpret the fact that age-weighting is not typically used as an indication that global health scholars believe it should not be used when making resource allocation decisions. Rather, they believe that judgments about the relevance of such factors should be left to decision-makers.

It is potentially problematic that researchers usually do not include moral judgments in their work. Because of the complexity of researchers' models, policymakers may not realize that moral judgments have not been accounted for, and even if policymakers noticed and wanted to factor them in, they may not have the technical knowledge to revise the models to incorporate their ethical values.

Health improvements versus increases in consumption

Economists have conducted cost-benefit analyses on improving health versus increasing consumption. These studies draw both on preferences that people express explicitly and on their revealed preferences – i.e., hidden preferences that are revealed in their answers to questions like how much they are willing to spend on safety equipment or certain medications.

However, these studies may be biased by the wealth of the individuals responding and may not be representative of the decision-making process of poor individuals faced with the same questions. Some economists are attempting to account for this bias. Professor Marc Fleurbaey has proposed an “equivalent income” model, in which various sets of health states and income pairings are ranked to understand how much people value health relative to income.

Improving GiveWell's cost-effectiveness model

Professor Schroeder suggested a variety of ways that GiveWell's cost-effectiveness models could better enable users of the model to consider moral tradeoffs. Some of his suggestions included:

- Showing a range of possible results based on different populations' values (e.g., preferences of GiveWell staff vs. donor survey results vs. surveys of the general population).
- Illustrating health and development outcomes using detailed information and vignettes such as 1) What a 25% increase in consumption typically achieves for a person with a given baseline level of consumption in a specific part of the world, 2) (if evaluating cervical cancer) what the age is of a typical woman with cervical cancer, how many children she has, and what childcare options she has in the case of her death.

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