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| Abstract | <p>Norman Daniels's theory of 'accountability for reasonableness' is an influential conception of fairness in healthcare resource allocation. Although it is widely thought that this theory provides a consistent extension of John Rawls's general conception of justice, this paper shows that accountability for reasonableness has important points of contact with both utilitarianism and intuitionism, the main targets of Rawls's argument. My aim is to demonstrate that its overlap with utilitarianism and intuitionism leaves accountability for reasonableness open to damaging critiques. The important role that utilitarian-like cost-effectiveness calculations are allowed to play in resource allocation processes disregards the separateness of persons and is seriously unfair towards individuals whose interests are sacrificed for the sake of groups. Furthermore, the function played by intuitions in settling frequent value conflicts opens the door for sheer custom and vested interests to steer decision-making.</p> | |
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3 **If You're a Rawlsian, How Come You're So Close**
4 **to Utilitarianism and Intuitionism? A Critique**
5 **of Daniels's Accountability for Reasonableness**

6 **Gabriele Badano¹**

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9 **Abstract** Norman Daniels's theory of 'accountability for reasonableness' is an
10 influential conception of fairness in healthcare resource allocation. Although it is
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13 ness has important points of contact with both utilitarianism and intuitionism, the
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21 to steer decision-making.

22
23 **Keywords** Healthcare resource allocation · Accountability for reasonableness ·
24 Public justification · Norman Daniels · John Rawls

25
26
27 Norman Daniels is a key theorist in the field of justice and health. In particular, his
28 account of fair process in healthcare resource allocation, which constitutes the main
29 focus of my argument, is highly influential also beyond theoretical debates. It has
30 been used as a guide to policy-making on multiple occasions by, for example, the
31 British NHS, the Mexican government and the WHO.¹

1FL01 ¹ For the NHS, see NICE [17]. For Mexico and the WHO, see Daniels [4], pp. 274–296.

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32 Daniels's account of fair process, called 'accountability for reasonableness'
 33 (AFR), is the subject of much critical debate [1, 7, 9, 12, 24]. However, no
 34 commentator appears to take issue with Daniels's [4, pp. 29–30] belief that his
 35 theory constitutes an extension of John Rawls's hugely influential general theory of
 36 justice into the realm of health. In fact, much work in this area starts from the
 37 assumption that, like the rest of Daniels's theory, AFR provides a faithful translation
 38 of Rawls's account [7, 24].

39 This paper aims to demonstrate that AFR is vulnerable to important arguments
 40 advanced by Rawls. However, its interest is not limited to those who start from a
 41 commitment to Rawls's theory of justice. Besides playing a fundamental role in
 42 Rawls's account, the arguments that I intend to draw on are compelling in their own
 43 right and very relevant to healthcare resource allocation. My goal is to build upon
 44 these arguments to develop an original critique of AFR.

45 After reconstructing AFR, I draw on Rawls to argue that Daniels's failure to keep
 46 a safe distance from both intuitionism and the aggregative logic of utilitarianism
 47 severely damages his theory of fairness in healthcare resource allocation. Next, I
 48 briefly outline a future research direction that could be explored in attempting to
 49 revise AFR, namely a shift towards a different form of public justification
 50 liberalism.

51 Daniels's Model of Fair Process

52 AFR is connected with Daniels's analysis of the value of health. Daniels believes
 53 that health protects a person's range of opportunities to pursue life plans. Rawls's
 54 theory, along with several competing accounts of justice, provides reasons to protect
 55 opportunities and distribute them in an egalitarian fashion. Given that healthcare
 56 protects health, Daniels [4, pp. 29–78] maintains that healthcare should be regarded
 57 as special, which means that societies should provide universal access to it, in
 58 isolation from ability to pay and other social goods.

59 As important as the specialness of healthcare may be when it comes to organising
 60 healthcare systems at a general level, Daniels recognises that no principle of
 61 opportunity, Rawlsian or otherwise, is fine-grained enough to provide answers to the
 62 specific substantive questions that make up the routine of healthcare resource
 63 allocation agencies. Numerous substantive criteria are generally considered to be
 64 suitable for governing the allocation of scarce healthcare resources, while available
 65 theories of opportunity are too abstract to determine how these criteria should be
 66 traded off against each other when they conflict. Daniels lists three particularly
 67 important conflicts as representative of all others. How much priority for the sickest
 68 is justified vis-à-vis the production of greater aggregate health benefits? When
 69 should significant health benefits to a smaller number of persons be outweighed by
 70 the aggregation of more modest benefits to a larger number of persons? How should
 71 the value of a fair chance to derive some benefit from available resources be
 72 balanced against more cost-effective interventions? From the perspective of
 73 available theories of opportunity, a wide range of possible answers to each of
 74 these questions appear equally just [4, pp. 103–110].

75 To solve these conflicts, the principle of opportunity needs to be supplemented.
 76 Drawing on Rawls's notion of pure procedural justice, Daniels claims that resource
 77 allocation decisions should be regarded as just when they result from a fair decision-
 78 making process, where fairness must be understood in terms of the four conditions
 79 constituting AFR:

- 80 • **Publicity:** Decisions and supporting rationales must be transparently stated.
- 81 • **Relevance:** 'The rationales for limit-setting decisions should aim to provide a
 82 *reasonable* explanation of how the organization seeks to provide "value for
 83 money" in meeting the varied health needs of a defined population'. An
 84 explanation is reasonable if it is grounded in considerations that can be accepted
 85 *as relevant* by persons who are willing to provide justifications for the allocation
 86 of resources they support.
- 87 • **Revision and appeals:** Mechanisms must be in place to challenge decisions.
- 88 • **Regulation:** There must be uniform enforcement of the other three conditions.²

89 Relevance, which is supposed to constrain the substance of the reasoning leading to
 90 decisions, is the primary target of this paper's criticism. Relevance is very inclusive
 91 towards the substantive criteria that may be proposed as suitable for governing
 92 resource allocation. Indeed, a wide variety of criteria can be considered to have at
 93 least *some* relevance to the pursuit of some unspecified 'value for money' in
 94 meeting health needs. This leads to decision-makers adopting long lists of relevant
 95 criteria, as reflected in the practice of those real-world resource allocation agencies
 96 that apply AFR.

97 Consider the British National Institute for Health and Care Excellence (NICE),
 98 which not only endorses AFR, but is also typically described by Daniels [5,
 99 pp. 178–180] as a successful application of AFR's key ideas. Founded in 1999 and
 100 operating at arm's length from the Department of Health, NICE provides guidance
 101 in a number of areas, but is most often discussed for its compulsory recommen-
 102 dations on the coverage of pharmaceuticals and other health technologies in the
 103 NHS. Over time, NICE has progressively introduced a number of so-called 'equity
 104 weightings' to be balanced against the cost-effectiveness of health technologies to
 105 decide whether they should be funded.

106 To be sure, cost-effectiveness analysis (CEA) still plays a uniquely important
 107 role in NICE's process, in that equity weightings are only considered when the cost-
 108 effectiveness of a technology falls below a certain mark and, therefore, NICE needs
 109 reasons other than cost-effectiveness to justify a positive recommendation; beneath
 110 an even lower mark, the support provided by the equity weightings must be
 111 exceptionally strong for that technology to be funded despite its poor cost-
 112 effectiveness. Still, when the conditions are right, decision-makers can appeal to
 113 severity of disease, the potential for innovation of the technology under appraisal,
 114 stakeholder persuasion, the premium placed on benefits accruing to patients at the
 115 end of their lives, the extra priority for the members of disadvantaged groups and
 116 the special attention to be paid to children [17, 20]. In a recent consultation paper,

² Daniels [4, pp. 117–133, while the direct quotation of the relevance condition is from page 118, with emphasis in the original]. AFR draws on the work that Daniels has carried out with Sabin [5].

117 NICE [18] proposes that the wider societal benefits of technologies should be added
 118 to the list, and it is hard to see why this proposed criterion (and many others that
 119 could have been suggested with it) should be excluded if the question is merely one
 120 of relevance to the pursuit of value for money in meeting health needs.

121 To prepare the ground for my critique of Daniels, it is important to discuss CEA
 122 in greater detail. CEA is an aggregative criterion in that it combines the health gains
 123 and losses of different individuals into the health gain and loss of a group as a
 124 whole; its basic idea is that decision-makers should allocate available funds so as to
 125 create the greatest sum total of health benefits *aggregated across the population*.
 126 Health benefits are generally measured in terms of quality-adjusted life years
 127 (QALYs), which integrate life expectancy and health-related quality of life. To see
 128 how efficiently a certain intervention can foster the maximisation of aggregate
 129 benefits in the context of a limited budget, the cost of the intervention is divided by
 130 the number of QALYs that would be created by it. This gives the cost of the
 131 intervention per QALY added to the health of the population; the lower the cost per
 132 QALY, the greater the cost-effectiveness of an intervention [2, pp. 53–78].

133 Cost-per-QALY estimates for interventions are widely used, generally in
 134 conjunction with other criteria, to determine which interventions should and should
 135 not be funded. Daniels [4, p. 114] makes it clear that the three conflict cases, noted
 136 above, that he uses to justify AFR demonstrate that ‘CEA by itself cannot serve as a
 137 decision procedure’ for allocating healthcare resources. However, the exposition of
 138 his theory of AFR attaches great importance to cost-effectiveness—perhaps greater
 139 importance than that attached to any other relevant criterion. To see how, let us go
 140 back to the three conflict cases.

141 Although priority to the sickest, the premium placed on individual ability to
 142 benefit from intervention and the provision of fair chances may well clash with each
 143 other, none of Daniels’s conflict cases pits two of these quintessentially distributive
 144 considerations against one another. Each of Daniels’s cases, which are paradigmatic
 145 examples of the conflicts that AFR is meant to arbitrate, opposes the aggregative
 146 and maximising logic of CEA against a different consideration that stresses the
 147 importance of who receives the benefits. This suggests that an implicit assumption
 148 underlying AFR is that resource allocation processes have two high-order goals,
 149 which must be balanced: the maximisation of aggregate population health and the
 150 distribution of benefits fairly.³ Given that cost-effectiveness is one and the same as
 151 the former goal, virtually all the other relevant considerations are grouped together
 152 under the latter goal, highlighting an asymmetry between CEA and any other
 153 relevant criterion in the theory behind AFR.

154 As further support to the claim that CEA is not simply a relevant consideration
 155 among others, it is important to recall that Daniels defines the relevance condition as
 156 relevance to the goal of creating value for money. Given CEA’s commitment to
 157 creating as much good as possible from the money available for healthcare, the
 158 notion of value for money is commonly associated with CEA, to the point that this

3FL01 ³ An explicit reference to the conflict between maximisation and distribution is sometimes used by
 3FL02 Daniels to frame the problems facing the application of AFR to real-world resource allocation. For
 3FL03 example, see Daniels [4, pp. 253–254 and 303–304].

159 notion is sometimes almost reduced to cost-effectiveness [17, p. 4]. Again, it
 160 appears that the theory behind AFR has a particularly close link with the idea of
 161 cost-effectiveness.

162 Two Problems with Aggregation

163 My reconstruction depicts AFR as a conception of fair process in which decision-
 164 makers must allocate resources on the basis of cost-effectiveness calculations
 165 balanced against a wide variety of relevant countervailing considerations. In the
 166 introduction, we saw that Daniels and his commentators seem to agree that AFR
 167 works well as a supplement to Rawls's general theory of justice. My critique of AFR
 168 is prompted by the sense that they are missing something important.

169 Rawls [22, pp. xvii–xviii] clearly states that the main aim of his theory is to put
 170 forward a superior alternative to the only approaches to the allocation of societal
 171 resources that philosophers deemed viable in the 1960s, namely utilitarianism,
 172 intuitionism and, most appealing of all, a mix of them in which the principle of
 173 utility is restricted by intuitionistic constraints. This aim is grounded in compelling
 174 arguments against utilitarianism and intuitionism. My goal in this section and the
 175 next is to demonstrate that these arguments can be used to show that AFR is a
 176 flawed account of fairness in healthcare resource allocation. Indeed, when Rawls's
 177 arguments are adapted to the case of AFR, it will emerge that Daniels's model looks
 178 much like the mixed approach that Rawls wishes to find an alternative to.

179 Consider first Rawls's [22, pp. 19–30] argument against utilitarianism, which is
 180 the general view that societal resources should be allocated so as to maximise the
 181 sum total of satisfaction aggregated throughout all members of society. Rawls's
 182 argument can be thought of as consisting of two closely connected parts. To start
 183 with, Rawls argues that utilitarian institutions violate the separateness of persons. A
 184 single individual is free to impose a loss on herself in order to secure a greater gain,
 185 perhaps at a later date. However, utilitarianism requires that the losses imposed on
 186 *certain* individuals should be freely balanced against the gains accrued to *others*,
 187 therefore treating society as though it was a single person, produced through the
 188 conglomeration of all its members.

189 Given that CEA requires that the health losses to some be balanced against the
 190 health gains to others so as to maximise aggregated health benefits, CEA is affected
 191 by the same problem. Insofar as decision-makers employ CEA, the health gain and
 192 health loss of a social conglomerate influence resource allocation decisions in their
 193 own right, effectively making such a conglomerate into a somewhat monstrous
 194 independent unit of concern, above and beyond the concern due to individual
 195 members of society.

196 Also the second part of Rawls's argument targets an element that utilitarianism
 197 shares with CEA, namely the exclusive concern for the maximisation of aggregated
 198 benefits, as opposed to their distribution. If either utilitarianism or CEA plays any
 199 role in allocating limited resources, there will be cases in which decision-makers
 200 assign priority to giving a smaller benefit to each member of a larger group over a
 201 larger benefit to each member of a smaller group. The larger the role either

202 utilitarianism or CEA is allowed to play, the greater the sacrifices that individuals
 203 from the smaller group will be required to make in these sorts of conflict cases.
 204 According to Rawls, it is highly problematic to require that individuals make
 205 important sacrifices specifically *for the sake of a group*, as opposed to making
 206 important sacrifices because one or more other individuals have a stronger claim to
 207 available resources. The problem is the violation of the compelling idea, derived
 208 from the social contract tradition, that a just society is ultimately built on equal
 209 respect and concern *for individuals*, who enjoy a form of inviolability by the claims
 210 of groups as such.

211 A supporter of CEA could try to deflect my criticism by objecting that
 212 utilitarianism and similarly aggregative views are actually built on a separate
 213 concern for each person. As claimed by Hirose [10], this commitment to the
 214 separateness of persons is reflected in the principle that the well-being of everyone
 215 should count for one and no more than one for the purposes of the utilitarian
 216 calculus.⁴ It is unclear to me how the principle that the well-being of everyone
 217 should count for one in an interpersonally aggregative calculus expresses a
 218 commitment not only to impartiality between competing interests, but also to the
 219 separateness of persons, especially in the relevant moral sense of treating them as
 220 separate ultimate units of concern. Hirose [10, p. 196] anticipates this reaction, and
 221 he briefly comments that impartiality logically implies separateness; utilitarianism
 222 cannot be impartial between the well-being of Annie and Betty ‘unless it
 223 acknowledges the fact that Annie and Betty live different lives’.

224 However, this alleged logical relation linking impartiality *between interests* with
 225 the separateness *of persons* does not withstand scrutiny. A person can accept for
 226 herself a principle of rational choice requiring that the satisfaction of each of her
 227 interests should count for one (regardless, for example, of whether they qualify as
 228 higher or lower pleasures in a Millian sense) without transforming them into
 229 interests that, instead of all being part of her life plan, belong to different persons—
 230 and, moving close to the moral understanding of separateness, without taking the
 231 satisfaction of any of her interests to enjoy an inviolability that cannot be
 232 outweighed by any aggregation of other individually weaker interests of hers.

233 How damaging to Daniels is this Rawlsian-inspired twofold critique of CEA?
 234 Section “[Daniels’s Model of Fair Process](#)” explained that when presenting his
 235 theory of AFR, Daniels frames his arguments in a way that effectively gives a place
 236 of honour to the idea of cost-effectiveness. This already demonstrates Daniels’s
 237 failure to fully appreciate the strength of Rawls’s arguments against utilitarianism
 238 and their relevance to CEA. However, this is by no means all that can be said
 239 against Daniels. AFR also imposes too few constraints on the extent to which CEA
 240 can govern *the practice* of resource allocation, therefore condoning seriously unfair
 241 decision-making processes.

242 To be sure, I noted earlier that Daniels rejects the view that CEA should serve by
 243 itself as a decision procedure. However, AFR does *not* exclude processes for
 244 allocating resources that assign a high, albeit not absolute, priority to cost-
 245 effectiveness in its conflicts with distributive considerations. To give a concrete

4FL01 ⁴ See also Norcross [19, pp. 79–80].

246 example of such processes, we saw that Daniels typically depicts NICE as a
 247 successful application of AFR's key ideas, despite the especially important role that,
 248 as mentioned in section "[Daniels's Model of Fair Process](#)", CEA plays in NICE's
 249 procedures.

250 Consequently, AFR condones processes that are seriously flawed (according to
 251 the Rawlsian line of thought that I have developed in this section) by virtue of the
 252 large use of CEA they make and, therefore, by virtue of the great extent to which
 253 they are affected by the two problems with the aggregative logic of CEA. Indeed, if
 254 a resource allocation process decides in favour of cost-effectiveness in a wide range
 255 of conflict cases with the various countervailing considerations, (1) a great deal of
 256 the reasoning at the core of such a process is defective because it is built upon a
 257 misguided unit of concern, and (2) the process is seriously unfair towards those
 258 potential beneficiaries who are now required to sacrifice considerable individual
 259 claims simply for the sake of a group.

260 As a last defence of AFR, one might distinguish AFR itself (strictly understood
 261 as the framework made up of the core notions of publicity, relevance, revision and
 262 appeals, and enforcement) from the way in which Daniels presents and develops it.
 263 Next, it might be suggested that in itself, AFR is not necessarily vulnerable to my
 264 Rawlsian-inspired arguments against cost-effectiveness, in that CEA could simply
 265 be excluded as *irrelevant* to healthcare resource allocation based precisely on
 266 Rawls's objections to aggregation. My response to this ingenious way of moving
 267 beyond Daniels is that it stretches the concept of relevance too thin. The problems
 268 with aggregation identified by Rawls are not problems of irrelevance to the pursuit
 269 of value of money in the allocation of scarce resources. Therefore, the notion of
 270 relevance is simply ill-suited to narrowly constrain the use of cost-effectiveness. In
 271 turn, this means that AFR should be replaced by an account of fair process that has
 272 the necessary resources to impose stricter constraints on CEA, so as to exclude the
 273 serious instances of unfairness overlooked by AFR. To identify another weakness in
 274 this model, let us now discuss Rawls's argument against intuitionism.

275 **The Case Against Intuitionism**

276 According to Rawls's definition, intuitionists believe that (a) a plurality of
 277 irreducible substantive values apply to political issues and (b) there is no explicit
 278 principle for weighing such values against each other. Why is this approach called
 279 'intuitionism'? If a plurality of values apply to political issues, they will often
 280 conflict with one another. Given that there is no explicit principle for balancing
 281 values in all conflict cases or, at least, confining intractable value conflicts within
 282 narrow limits, intuitions are bound to greatly influence decision-making by
 283 determining how conflicts must be settled.

284 Rawls points out that intuitionism is particularly tempting when the focus is on
 285 specific public policy areas such as fair wages and—we may add—healthcare
 286 resource allocation. I argue that AFR yields to this temptation, effectively proposing
 287 an account of fair process in which cost-effectiveness is intuitively balanced against
 288 a plurality of other substantive criteria. Section "[Daniels's Model of Fair Process](#)"

289 established the link between Daniels's relevance condition and long lists of criteria.
 290 Moreover, Daniels's case for AFR demonstrates that, according to him, explicit
 291 principles for weighing those criteria against each other are unavailable; we need
 292 AFR precisely because available theories of opportunity cannot explain how to
 293 balance CEA against the numerous other criteria that appear to be suitable for
 294 governing resource allocation. Consequently, decision-makers following AFR are
 295 bound to make frequent use of intuitions when cost-effectiveness conflicts with
 296 other relevant criteria.

297 What is the problem with the work done by intuitions in settling value conflicts?
 298 Intuitions are opaque in the sense that a person cannot be expected to satisfactorily
 299 explain to others why her intuitions favour one possible solution to a value conflict
 300 over others. Hence, Rawls [22, pp. 30–36] maintains that *vested interests and sheer*
 301 *custom* are free to hide behind intuitive judgements to determine the solutions to
 302 value conflicts in a way that is virtually impossible to detect. The risk is that sheer
 303 power and status-quo bias hijack decision-making without even being detected.

304 Rawls's argument against intuitionism is particularly relevant to healthcare
 305 resource allocation decisions because of the context in which such decisions are
 306 made. This context, which I will now briefly discuss, makes it all the more likely
 307 that the use of an intuitionistic approach such as AFR ends up serving as a
 308 smokescreen for status-quo bias and, more importantly, for vested interests to steer
 309 the decision-making. This result violates the very notion of fairness that Daniels
 310 wishes to place at the basis of AFR, namely fair process as a transparent exchange
 311 of reasons in the search for resource allocation arrangements that truly guarantee
 312 value for money spent.

313 Agencies responsible for allocating healthcare resources are on the receiving end
 314 of a huge amount of pressure exerted by multiple lobbies. To cite but a few
 315 examples, the enormous lobbying power of pharmaceutical industries is always at
 316 work to loosen the constraints on drug coverage that resource allocation agencies
 317 impose in the attempt to stay within their budgets. The interests of Big Pharma
 318 generally converge with the interests of patient advocacy groups, while the media
 319 constitute another important actor, which has traditionally been keen to launch
 320 campaigns against resource allocation efforts. On top of all this, elected politicians
 321 often have incentives to side with such lobbies. In sum, as claimed by Williams
 322 et al. [30, p. 90], 'the interplay of interest group agendas is nowhere more significant
 323 than in healthcare'.⁵

324 As an example of the pressure exerted by lobbies, consider the case of Herceptin
 325 in the UK. As explained by Ferner and McDowell [6, p. 1269], Herceptin well
 326 exemplifies the ability of pharmaceutical companies to make the general public
 327 attuned to a promotional message about a drug long before licencing, through
 328 enthusiastic press releases and exhortations to spread the word, delivered as soon as
 329 positive results start to emerge from early trials. In 2005, the drug had been used for
 330 a few years to treat advanced breast cancer under the NHS, and pressure mounted on
 331 the NHS after positive results in the treatment of early-stage breast cancer had
 332 started surfacing. Newspapers published numerous stories, attacking what was

5FL01 ⁵ See also Goddard et al. [8].

333 depicted as red tape that was denying many women access to a wonder treatment.
 334 Patient advocacy groups did their part, with one of them marching on Downing
 335 Street in September 2005 to submit a petition.

336 Local commissioning authorities, at the time called ‘primary care trusts’ (PCTs),
 337 were ultimately responsible for choosing whether NHS providers in their area
 338 should start offering Herceptin to early-stage breast cancer sufferers. At that stage,
 339 the European Medical Agency had not yet received the necessary information to
 340 assess the safety of Herceptin in the treatment of early-stage breast cancer in order
 341 to issue a licence. Thus, PCTs were pressurised into making coverage decisions not
 342 only before NICE could appraise value for money, but also before safety issues
 343 could be assessed. Nonetheless, politicians went to great lengths to ensure that as
 344 many PCTs as possible would cover Herceptin. In a Department of Health press
 345 release, the Secretary of State for Health, Patricia Hewitt, declared that she wanted
 346 to see Herceptin in widespread use. She went as far as to meet with the staff of one
 347 of the PCTs that had upheld the principle that the licensing process should not be
 348 bypassed—unsurprisingly, the decision taken by the PCT was reversed after the
 349 meeting [6, 28, pp. 1–9].

350 We can now appreciate the full potential for damage that the intuitionistic
 351 approach embedded in AFR is likely to inflict upon the fairness of healthcare
 352 resource allocation processes. The Herceptin case is only a particularly egregious
 353 example of the sort of pressure that, as encapsulated in the words of Williams and
 354 colleagues, vested interests routinely put on resource allocation. If we accept that a
 355 plurality of values apply to resource allocation and only intuitions can settle their
 356 conflicts, decision-makers are offered the ‘easy’ option of giving in to that pressure
 357 while also obfuscating the fact that vested interests are effectively governing the
 358 decision-making.

359 Daniels himself stresses that a great deal of disagreement exists, among both
 360 theorists and ordinary persons, about how to balance conflicting criteria for making
 361 decisions and answer specific healthcare resource allocation questions; many
 362 different orderings of criteria and many different decisions seem right to different
 363 persons. Therefore, if we exclude strikingly implausible arrangements, decision-
 364 makers following AFR often have the option of appealing to intuitions to justify an
 365 ordering of conflicting criteria that leads to a decision that favours the most
 366 powerful lobbies with an interest in the issue at hand. In sum, given the context in
 367 which healthcare resource allocation takes place, the intuitionistic nature of AFR
 368 creates a very high risk that powerful vested interests will steer decision-making
 369 without even being detected, violating Daniels’s own idea of fairness as transparent
 370 reason-giving by decision-makers in search of truly valuable resource allocation
 371 arrangements.

372 It is important to pause a little longer over the intuitionistic character of AFR, to
 373 forestall any misunderstanding of my argument. Readers might wonder whether my
 374 argument only works because it has narrowly focused on relevance, apparently
 375 forgetting about publicity and the other conditions of AFR. I have not forgotten
 376 about them, and I believe that transparent reason-giving can help considerably in the
 377 fight against status-quo bias and vested interests, as can be illustrated by going back
 378 to the Herceptin case. It is hard to imagine any local commissioner openly declaring

379 that they have decided to fund Herceptin because they wish to please the
 380 pharmaceutical industry, or even because they simply want the Secretary of State
 381 and pressure groups off their back. Among other things, these sorts of rationales
 382 would have likely faced challenge had PCTs had any internal appeals process.
 383 Therefore, AFR is better suited to curb the influence of status-quo bias and vested
 384 interests than so-called systems of ‘implicit rationing’, where the processes through
 385 which healthcare resources are allocated are not publicly acknowledged.

386 However, precisely because I appreciate the importance of publicity in the
 387 justification of decisions, I believe that the intuitionistic character of AFR still
 388 creates a problem. The frequent *intractable* value conflicts that, as we have seen,
 389 AFR is meant to deal with create a space that is *by its nature closed to transparent*
 390 *reason-giving* and, in turn, to the protection transparency offers against sheer
 391 custom and vested interests. This feature of value conflicts that are taken to be
 392 intractable to explicit principles has been stressed both by critics and proponents of
 393 publicity. One of Mechanic’s [13, 14] argument for implicitly ‘muddling through’
 394 healthcare resource allocation decisions is that, to strike the right balance among the
 395 many considerations relevant to the problem at hand, decision-makers often have to
 396 make judgement calls that, by their very nature, cannot be transparently explained to
 397 others. At the other end of the spectrum, Richardson [23, pp. 287 and 305,
 398 respectively] criticises intuitive balancing precisely because the grounds for
 399 accepting a certain ordering of conflicting values as intuitive will always be
 400 ‘mysterious’ from the perspective of others, and will never be ‘open to rational
 401 public debate’. It is through this opaque process for arbitrating value conflicts that
 402 status-quo bias and vested interests risk creeping back, at least in some measure,
 403 into decision-making procedures governed by AFR.

404 My discussion of Herceptin was meant to give a sense of the sheer amount of
 405 pressure faced by healthcare resource allocation decision-makers—a pressure so
 406 strong that it sometimes threatens the standing of resource allocation agencies in
 407 society, if not their prospects for survival [25, p. 23]. It is against this background, I
 408 reiterate, that we should assess the risks involved in AFR admitting long lists of
 409 values into decision-making while acknowledging that many different orderings of
 410 values and, therefore, many different resource allocation decisions seem right to
 411 different persons. The need to intuitively balance conflicting values will often create
 412 a chance for decision-makers to yield to that huge pressure by publicising as
 413 intuitive to them the ordering of relevant values that leads to the decision favoured
 414 by the most vocal or otherwise most powerful interest groups.

415 This problem constitutes a serious flaw in Daniels’s model. It is a problem that
 416 might not be completely solvable; as acknowledged by Rawls, it is implausible to
 417 completely eliminate intuitions from the process of adjudicating value conflicts.
 418 However, it is important to find a way to make the problem associated with
 419 intuitions less serious than it is under AFR by confining the use of intuitions within
 420 narrower limits. As sketched in the next section, an option worth exploring is to
 421 develop the notion of public justification beyond AFR’s conditions, in a way that
 422 imposes a tighter frame of reasoning on decision-makers.

423 **What Next?**

424 This paper has shown that AFR is vulnerable to powerful arguments originally
 425 advanced by Rawls, leaving us with the task of developing a revised account of
 426 fairness in resource allocation that does more to limit the role of CEA and confines
 427 intuitions within narrower limits. This is an extremely complicated task, and I am
 428 forced to leave its completion for another day. However, I wish to briefly sketch a
 429 possible research direction that will be worth considering, perhaps among others,
 430 when examining how to revise AFR.

431 AFR's problems are due to the relevance condition, whose inclusivity leads to
 432 long lists of criteria being admitted into decision-making and is hospitable towards
 433 procedures that make extensive use of CEA. The other conditions help ease those
 434 problems, at least regarding sheer custom and vested interests, but do not go far
 435 enough. Therefore, although publicity, revision and appeals, and enforcement
 436 should be retained, a fitting substitute should be found for relevance. Daniels
 437 himself [3, pp. 201–202] points us in an interesting direction when he clarifies that
 438 AFR incorporates a principle of universal acceptability among reasonable persons,
 439 but only in the 'attenuated' sense that everyone must be able to see the relevance of
 440 the rationales. He admits that there are 'fuller' conceptions of universal
 441 acceptability, which seem a promising place to look for candidates for replacing
 442 relevance.

443 A possible replacement, which embraces acceptability *without strings attached*,
 444 requires that decision-makers strive to ground resource allocation decisions in
 445 rationales that each reasonable person can accept, where reasonable persons are
 446 understood to be those who are themselves committed to decisions that everyone
 447 similarly motivated can accept. This requirement could be called the 'full
 448 acceptability condition', and closely resembles classic formulations of the duty of
 449 public justification for binding decisions,⁶ already brought to bear on issues of
 450 distributive justice by Nagel [16]. Also, this requirement is virtually identical to
 451 classic formulations of contractualism in the debate over the distribution of scarce
 452 benefits, as exemplified, once again, by Nagel and also by Scanlon's [27] idea that
 453 decisions should be made according to principles that no one could reject in a
 454 situation in which everyone is committed to proposing principles that no other
 455 similarly motivated person could reject.

456 Thus far, I have only laid out the definition of the full acceptability condition. But
 457 how do its requirements differ from those imposed by relevance on resource
 458 allocation? Why is the full acceptability condition an option worth considering?
 459 First, it would impose limits on the use of CEA well beyond those set by AFR.
 460 Contractualists explain that when applied to the distribution of scarce benefits, the
 461 requirement to look for arrangements that everyone can accept (or no one can reject)
 462 imposes *a rather specific and considerably tight frame of mind on decision-*
 463 *makers*—one that asks them to carry out pairwise comparisons between the
 464 perspective of each potential beneficiary and that of every other, which in turn pull

6FL01 ⁶ This duty is most famously captured by the theory of public reason proposed by Rawls [21,
 6FL02 pp. 212–254].

465 strongly towards a commitment to assigning priority according to the strength of the
 466 claims to resources that potential recipients of intervention can make as individuals.
 467 To see how this tight frame of reasoning is derived, recall that resource allocation
 468 decisions are bound to create winners and losers. Nagel [15, p. 123] points out that
 469 in these circumstances, no decision can be completely acceptable to everyone.
 470 Therefore, decision-makers committed to universal acceptability have to settle for
 471 the arrangement that is most acceptable to the person to whom it is least acceptable.
 472 Nagel suggests that the decision that is most acceptable to those to whom it is least
 473 acceptable should be identified through pairwise comparisons, with the aim of
 474 identifying which member of each pair has stronger grounds for rejecting a resource
 475 allocation arrangement that does not help her.⁷

476 What matters for the purposes of my argument is that, as contractualists make
 477 clear, *no interpersonal aggregation* is part of this reasoning method. The basic idea
 478 here is that aggregative and maximising principles can only satisfy acceptability *to a*
 479 *single point of view that combines all individual perspectives* into one, while this
 480 frame of reasoning aims for acceptability *to each individual perspective*.⁸

481 By themselves, AFR's original conditions could not have imposed this tight non-
 482 aggregative frame of reasoning. Section "Two Problems with Aggregation" already
 483 explained that the notion of relevance is ill-suited to place strict constraints on the
 484 use of aggregative principles. A similar point can also be made about publicity as
 485 understood by AFR, i.e., as disclosure of decisions and supporting rationales to the
 486 general public. It seems implausible to assume that the members of the public who
 487 are concerned with healthcare resource allocation are generally committed to the
 488 specific way of reasoning about it that involves placing oneself (at least
 489 schematically) in the shoes of each potential beneficiary, in order to identify who
 490 has the strongest claim to available resources. This commitment presupposes a
 491 strongly altruistic attitude, which is a lot to expect, especially in an area of debate
 492 where the members of certain patient groups have much to lose. Moreover, it
 493 presupposes a very specific way of giving shape to that attitude—one concerned
 494 with acceptability to each. Without any widespread and strongly-felt commitment of
 495 this sort in the real world, it seems a stretch to suggest that by itself, transparency
 496 could push decision-makers progressively closer to the anti-aggregative frame of
 497 reasoning that is integral to the universal acceptability condition.

498 Now, although free from aggregation, the reasoning method that is imposed by
 499 universal acceptability is usually proposed by contractualists as part of sophisticated
 500 theories, which include arguments suggesting that such a method converges on the
 501 same conclusions as CEA in certain cases where aggregative methods give
 502 intuitively right answers. Most notably, the non-aggregative reasoning imposed by
 503 the full acceptability condition is said to prioritise helping the greater number in

7FL01 ⁷ See also Nagel [16, pp. 63–74] and Scanlon [26, pp. 119–123].

8FL01 ⁸ Nagel [15, p. 86]. In the same passage, Nagel also rightly notes that a 'schematic' rendering of
 8FL02 individual claims, which can therefore be considered 'in essentials', would suffice. In the interest of
 8FL03 practicality (and without involving any interpersonal aggregation), it would therefore be admissible to
 8FL04 create, for example, a prioritised list that ranks healthcare interventions based on the strength of the
 8FL05 claims that *typical* individual members of different patient groups can make to them, ignoring certain
 8FL06 differences among individual members of the same group or sub-group of patients.



504 conflict cases between differently-sized groups of otherwise similar potential
 505 beneficiaries [27, pp. 231–235; and 11, pp. 48–77]. Also, given that it seems fair to
 506 say that the strength of an individual’s claim depends in part on the extent to which
 507 she could benefit from intervention [15, p. 125; and 26, p. 123], non-aggregative
 508 reasoning appears to have an answer to the so-called ‘bottomless-pit problem’,
 509 posed by patients who are extremely badly-off, but only capable of receiving trivial
 510 benefits.

511 Moreover, the theories behind non-aggregative reasoning are sometimes so
 512 sophisticated as to argue that there are specific circumstances in which non-
 513 aggregative reasoning itself requires passing matters on to CEA or other aggregative
 514 methods, as in conflict cases between a smaller group of potential beneficiaries and
 515 a larger group with claims that, although weaker, are strong enough to remain
 516 relevant. Building on previous work by Voorhoeve [29] argues that in these cases,
 517 non-aggregative reasoning cannot identify any arrangement that every reasonable
 518 person can accept, therefore abdicating the matter to aggregative reasoning. If
 519 considered together with the instances of convergence, would this limited role for
 520 CEA allowed by full acceptability be enough to create a plausible account of
 521 resource allocation? If not, would minor adjustments be sufficient? Also, are the
 522 arguments highlighting convergence with and a role for cost-effectiveness solid?
 523 These are some of the questions that a full evaluation of the full acceptability
 524 condition would have to tackle. On the face of it, however, this condition seems
 525 promising precisely because the problematic logic of aggregation would be much
 526 more rigidly constrained than under AFR.

527 The second reason why the full acceptability condition deserves attention
 528 concerns intuitions. We have just seen how precisely the reasoning method required
 529 by full acceptability dictates when aggregation is and is not allowed, going well
 530 beyond AFR’s laxer relevance and publicity conditions. This reduces to a minimum
 531 the need to resort to the intuitions of decision-makers to solve the conflict cases
 532 opposing cost-effectiveness (or any other aggregative criterion, for that matter) to
 533 any countervailing consideration, as in Daniels’s three paradigmatic conflicts. In all
 534 such cases, the full acceptability condition itself offers specific answers.

535 Of course, many criteria that are used to allocate healthcare resources do not
 536 involve aggregation, and they may conflict with one another. However, earlier in
 537 this section we saw that, in virtue of the tight frame of reasoning that full
 538 acceptability, but not relevance or transparency, imposes on decision-makers, full
 539 acceptability leads to a commitment to assigning priority according to the strength
 540 of individual claims. Consequently, a criterion should only be included in public
 541 justification if it can be represented as providing the basis for the claims of affected
 542 individuals to available resources. A hypothesis that seems worthy of future analysis
 543 is that the full acceptability condition would also exclude several criteria that,
 544 although not obviously aggregative, are nonetheless resistant to being represented as
 545 bases for individual claims. Simply by browsing NICE’s list of relevant criteria as
 546 described in section “[Daniels’s Model of Fair Process](#)”, we come across the
 547 principle that extra priority should be assigned to technologically innovative drugs
 548 and the idea that drugs that stakeholders consider to be priorities should be given
 549 extra importance, independent of the support offered to them by other criteria.

550 Criteria like these seem to satisfy Daniels's relevance while being *impersonal* in the
 551 relevant sense, justifying further analysis that would seek confirmation that they
 552 cannot be recast as bases for individual claims and, therefore, that they should
 553 indeed be excluded from deliberation.

554 Given that fewer criteria create fewer opportunities for conflict, and fewer
 555 conflicts lead to a decreased need for intuitive balancing, a shortened list of criteria
 556 confines the use of intuitions within narrower limits. Although intuitions are far
 557 from eliminated, detailed instructions regarding aggregation and a shorter list of
 558 criteria than under AFR appear to reduce the volume of intuitive judgements
 559 involved and, therefore, the risks associated with their being by nature closed to
 560 public scrutiny.

561 Conclusion

562 In the previous section, I suggested that full acceptability seems worthy of attention.
 563 From the perspective of this paper, however, the merits of full acceptability or any
 564 other specific alternative to relevance are secondary; my main goal has been to
 565 argue against AFR, demonstrating that we must search for a revised account of
 566 fairness that somehow imposes stricter constraints on CEA and confines intuitions
 567 within narrower limits.

568 Going back to the question asked by the title of this paper, it is not difficult to
 569 understand why Daniels proposes a theory that has so much in common with the two
 570 main critical targets of Rawls's theory of justice. Certainly, it has not been my
 571 intention to suggest that Daniels has not paid enough attention to Rawls's
 572 arguments. Rather, Daniels appears to be interested in providing a framework for
 573 the allocation of resources by often unRawlsian actual persons, many of whom
 574 place considerable weight on cost-effectiveness and take long lists of values to be
 575 relevant to resource allocation. This interest is, of course, fully understandable.
 576 However, by reconstructing Rawls's arguments, and by bringing them closely to
 577 bear on healthcare resource allocation, I have aimed to flesh out the full extent of the
 578 damage suffered by AFR in the process of accommodating real-world tendencies.
 579 Therefore, my conclusion is that Daniels has been too generous to such tendencies,
 580 and that theorists should now put greater effort into understanding the direction in
 581 which they should be reformed.

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