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The Case for Valuing Non-Health and Indirect Benefits

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INTRODUCTION

Health policy is only one part of social policy. Although spending administered by the health sector constitutes a sizeable fraction of total state spending in most countries, other sectors such as education and transportation also represent major portions of national budgets. Additionally, though health is one important aspect of economic and social activity, people pursue many other goals in their social and economic lives. Similarly, direct benefits—those that are immediate results of health policy choices—are only a small portion of the overall impact of health policy. This chapter considers what weight health policy should give to its "spill-over effects," namely non-health and indirect benefits.

DEFINITIONS AND THE STATE OF THE DEBATE OVER INDIRECT AND NON-HEALTH BENEFITS

Many health policy choices produce indirect and non-health benefits. For instance—as we will discuss—investing resources into treating infections acquired by new mothers produces an indirect benefit to their newborn children. It also produces many non-health benefits for the mothers, such as improved finances and greater capacity for social participation.

In light of the heated debate over the proper definition of health,[1] we adopt a definition of non-health benefits that should be compatible with any definition

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of health: a non-health benefit is any benefit that is not a health benefit. Though we sometimes use specific examples of what we assume constitute health or non-health benefits, readers can always choose a different example that fits their preferred account of health. Most questions about the relative priority of health and non-health benefits do not hinge on which definition of health is adopted.[2]

Defining indirect benefits is more complex. Some define indirectness in terms of purpose: an intervention's indirect benefits comprise its unintended but beneficial results. Others define indirectness in terms of causal distance: on such a definition, an intervention's indirect benefits are all its beneficial but not causally immediate results. Still others define indirect benefits using a "recipient conception," on which indirect benefits are solely those that result from the improved health of individuals who receive direct benefits (e.g., economic benefits resulting from the greater productivity of workers who receive direct benefits).

Dan Brock suggests that "if benefits of health interventions are indirect they are usually non-health as well, and vice versa."[3] We agree. However, this does not reflect any conceptual connection between indirect and non-health benefits, but rather the fact that the indirect and non-health benefits of most interventions are far more numerous than their direct or health benefits. This has much to do with the sheer breadth of what counts as an indirect or a non-health benefit.

The most prominent defenses of the claim that indirect and non-health benefits should be ignored or given lower priority have come from Brock and from Frances Kamm.[4] Kamm and Brock both draw on work outside the medical context: Kamm appeals to Immanuel Kant's idea that people should not be treated as mere means,[5] while Brock appeals to Michael Walzer's theory of separate spheres.[6] Meanwhile, the opposite view has been defended by Kasper Lippert-Rasmussen and Sigurd Lauridsen[2] and more recently (in the context of indirect benefits) by Jessica du Toit and Joseph Millum.[7]

This chapter will defend the view that indirect and non-health benefits should not be given lower priority than direct health benefits, and will do so specifically in the context of priority-setting in global health. Its approach can be conceptualized as a criticism of two existing approaches to health policy, which we call *No Consideration* and *Unequal Consideration*:

- *No Consideration* approaches give no weight at all to non-health and/or indirect benefits when determining which health policies to adopt.
- *Unequal Consideration* approaches give lesser weight to non-health and/or indirect benefits when determining which health policies to adopt.

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The chapter concludes that there is a decisive case against *No Consideration* approaches. It also concludes that there is a compelling case against *Unequal Consideration* approaches, and therefore in favor of giving no special consideration to direct health benefits as such.

INDIRECT AND NON-HEALTH BENEFITS: A CASE STUDY

To see how a medical intervention has indirect and non-health benefits, consider a case discussed by Miljeteig et al. in Chapter 3: payment for antibiotic treatment to cure a postpartum infection suffered by a new mother (Figure 12.1). We analyze some categories of indirect benefits produced by the intervention in Table 12.1.

Funding the intervention has the intended and immediate (direct) benefit to the patient of curing the infection, but it also has a variety of indirect, non-health effects. For instance, it has a direct non-health benefit to third parties by preventing health workers from having to pay out of pocket for patients' medicines, a phenomenon Miljeteig et al. discuss. This benefit can in turn produce indirect non-health benefits; for instance, it can benefit health workers' dependents by freeing up resources to be spent on their education. It also has indirect health effects because it reduces the odds that the newborn will contract the mother's infection, which improves its health and its longer-term educational prospects. And it produces indirect, non-health benefits for the new mother by improving her finances and earning power, which will likely in turn improve her health in other ways (an indirect health benefit) and enable her to gain more education. Improved education and wealth for the new mother is also likely to improve the health of her newborn. The intervention also has health and non-health costs not represented in Figure 12.1, such as opportunity costs to the health care system and the potential encouragement of antibiotic resistance.

In an environment of finite resources, health policy must not only deliver interventions but also set priorities. Because interventions differ not only in the direct health benefits they produce but also in the indirect and non-health benefits they produce, priority-setting decisions frequently will depend on what weight, if any, health policy assigns to indirect and non-health benefits.

WHY MIGHT INDIRECT OR NON-HEALTH BENEFITS WARRANT LOWER PRIORITY?

This section will evaluate several arguments for the conclusion that health policy should ignore indirect and non-health benefits or give them less weight:

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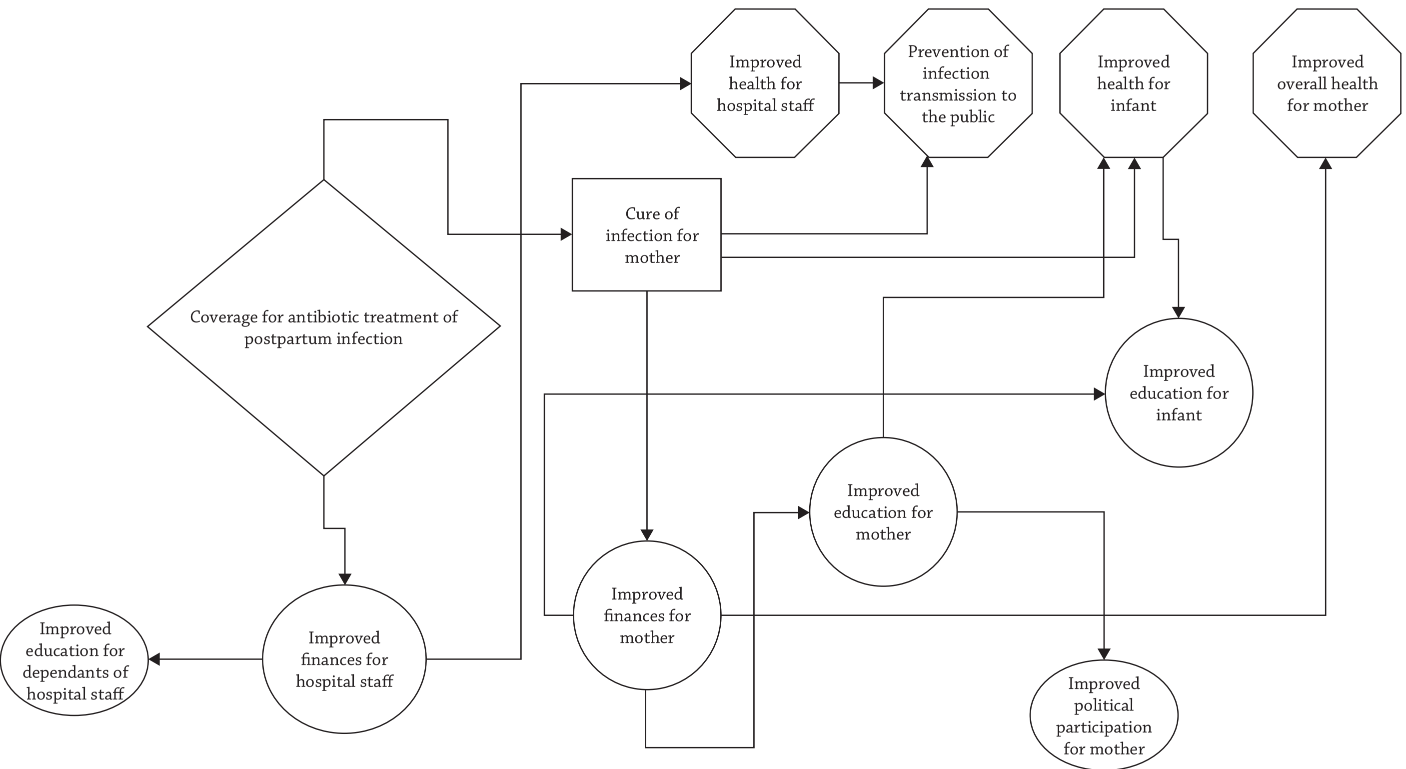

FIGURE 12.1. Some effects of a medical intervention.

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TABLE 12.1.

Categories of Indirect Benefits

	Direct	Indirect		
		Recipient-produced, 3rd-party received	Recipient-produced, recipient-received	Otherwise produced
Health	Cure of postpartum infection for new mother	Improved health for child	Prevention of poverty-caused illness for new mother	Improved health for doctor due to employment
Non-Health	Employment for health worker	Care for child	Income for new mother	Schooling for children of health worker

1. Health policy actors have a *role obligation* to prioritize provision of direct health benefits.
2. The *purpose* of the goods distributed by health policy is the provision of direct health benefits.
3. Direct health benefits are *more important* than other benefits.
4. An *adversarial* system where health policy focuses on the provision of direct health benefits, while other policy areas focus on other benefits, will lead to better overall results.
5. Given the breadth of what counts as an indirect or non-health benefit, if health policy pays (equal) attention to these benefits, we risk giving (equal) weight in health care allocation and prioritization choices to effects about which we have *imperfect information*.

Role Obligations

The claim that certain health professionals are obliged to prioritize the provision of direct health benefits has been most debated at the micro-level of health promotion, which involves interactions between health professionals and their patients. Many accounts describe physicians' role obligations as especially focused on promoting the health of the patient in front of them.[8] However, others have pointed out that patients have interests other than health.[9] This has engendered a debate regarding what weight physicians should give to values such as respect for patients'

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autonomy, preservation of their financial solvency, or promotion of public health. For instance, the antibiotic that most reliably cures postpartum infection may be the most expensive for patients or may already be overused, posing the danger of antibiotic resistance and ensuing bad consequences for public health.

Even if physicians' roles oblige them to give special weight to direct health benefits, those involved in making and implementing health policy likely have different role obligations. These actors have no fiduciary obligation to specific patients, and their expertise is not exclusively focused on the provision of health care. Indeed, health policy implementation is sometimes intertwined with the provision of non-health benefits. For instance, in the United States, the primary federal agency implementing health policy is the Department of Health and Human Services, which is responsible not only for health care programs like Medicare and Medicaid but also for the provision of non-health benefits such as early childhood education, refugee resettlement, and energy assistance. This renders dubious the claim that the internal morality of health policy requires giving special weight to health benefits.

Role obligations can also arise via delegation rather than being internal to a role, if the authority delegated to health policymakers comes with the proviso that it will be used to secure direct health benefits rather than indirect or non-health benefits. Whether authority is in fact delegated in this way represents an empirical question; in the section later in this chapter on adversarial efficiency, we evaluate one argument in favor of a policy of such delegation.

The Purpose of Health Care

The purpose or meaning of health care may appear to support giving special priority to direct health benefits when distributing health care. Frances Kamm has argued that certain resources (such as medicines) should be used for the purpose for which they are specifically designed.[4] However, Kamm's argument faces several problems. First, no consensus exists regarding the purpose of many medical resources.[7] Further, assigning moral weight to purpose seems vulnerable to a variety of *reductio ad absurdum* arguments. Consider the case of thalidomide, a teratogenic drug initially developed and prescribed as a sedative but later discovered to be a cancer treatment. Kamm's view would appear to count against the use of thalidomide to treat cancer, because thalidomide was originally developed and marketed as a sedative, though its risks when used as a sedative far outweigh its benefits. This objection might be rebutted by redescribing thalidomide's purpose in a more general way, for instance as health promotion rather than sedation. However, even after such redescription, a purpose-based view continues to have

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bizarre implications. For instance, it would imply that there would be something wrong about selling an antique bottle of thalidomide to raise money for educational efforts.

Furthermore, health care is only a small part of what health policymakers distribute. As Brock concedes, when the resource being distributed is money, "no direct argument that the distinctive end of what is being distributed is health seems applicable."[3] The same seems true for many other resources, such as legal protection or infrastructure. So even if a purpose-based argument like Kamm's can survive the above objections, its applicability is limited.

The Unique Importance of Health

The purpose-of-health-care argument involved the allocation of a *means*, health care. In contrast, the argument that health is uniquely important involves the allocation of an *end,* namely health. Because indirect and direct health benefits both improve health, the argument that health is uniquely important does not favor direct over indirect benefits. It does, however, favor health benefits over non-health benefits.

Brock uses Michael Walzer's "separate spheres" argument to support the claim that health is uniquely important. Walzer contends that different distributive principles apply to different sorts of goods: education should be distributed by different rules than money, and health by a rule different from either. However, even if we agree with Walzer that health is *unique*—that it should be distributed differently from other goods and cannot simply be subsumed under the general category of well-being[10]—this is not enough to support prioritizing health benefits. Consider an analogy: you, the reader, are special and different from every other person, but this does not justify the conclusion that we should prioritize you over others. The uniqueness of health will only justify prioritizing health benefits if health is also uniquely *important*—a conclusion for which the separate spheres approach offers no support. If health policy focuses only on optimizing health outcomes, it may render the distribution of other goods highly suboptimal. Contrary to what Lippert-Rasmussen and Lauridsen suggest, the separate spheres approach does not ignore the effects of the distribution of health on the distribution of other goods.[2] Such an interpretation of the separate spheres approach confuses Walzer's stance that we should strive to *minimize* the effects of health on other goods with the much less plausible claim that we should *ignore* those effects even if they exist. Walzer's stance is that we should publicly fund universal health care in order to ensure that an individual's health does not affect her access to non-health goods; it does not follow, and Walzer does not argue, that in the absence of

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publicly funded universal health care, we should ignore the effects of health care costs on the distribution of other goods.[6] Rather, we should ensure that health care provision does not (for instance, through its costs) lead to a maldistribution of other goods.[11]

An argument that health is not only unique but uniquely important must therefore rest on some basis other than separate spheres. One such basis would be the claim that health is a paramount good that must not be sacrificed to any other. This claim seems most plausible when we consider certain aspects of health, such as being alive rather than dead: other goods, such as education or political participation, are of no value to a dead person. Yet even the value of life can reasonably be sacrificed in order to achieve other goods: consider an individual who risks her life in order to participate politically, or—more prosaically—exposes herself to the risk of death on the road in order to commute to school. This is true not only for risks to health, but even sometimes for direct health losses: consider a mother who endures pain to give birth to a child, or a soldier who sacrifices life itself to block a grenade blast. These tradeoffs become even more plausible when we consider aspects of health less central than life itself.

Another basis for giving health special weight is Norman Daniels's claim that "health is of special moral importance because it contributes to the range of opportunities open to us"[12] Allen Buchanan has persuasively argued that employing Daniels's approach to justify what we call a *No Consideration* view, on which health benefits are given exclusive priority, will lead to absurd conclusions such as the investment of all resources in those who are critically ill.[13] But examination of Daniels's claim also reveals that giving health benefits *greater* priority than other benefits merely because of the kind of benefits they are—the view we called *Unequal Consideration*—is mistaken. As Lippert-Rasmussen and Lauridsen observe,

> Because healthcare often plays a more important role in preserving a normal range of opportunities than, say, modest extra income . . . in general, one should not ignore the healthcare needs of the unemployed in order to give better treatment to economically productive people. However, it is also clear that some non-health-related interests, such as basic education, are no less important determinants of one's range of opportunities than health is.[2]

Though types of health benefits serve as what we might call "keystone benefits" for preserving a normal opportunity range, the same is true for some non-health benefits. Similarly, some health and non-health benefits are not crucial to maintaining a normal range of opportunity. Accordingly, the goal of ensuring that

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each individual enjoys a normal opportunity range does not support assigning any benefit greater priority merely because of the *type* of benefit it is. Rather, we should provide whatever package of benefits best secures equality of opportunity.

Adversarial Efficiency

Many claim that administrative agencies and ministries each pursue disparate goals, rather than all pursuing some overarching goal such as the common good. Brock, for instance, quotes Robert Goodin's claim that "it is the Health Minister's job to look after health, and spend her money however best promotes health; any spillovers to non-health matters, be they positive or negative, are naturally neglected by her on the grounds 'that's not my department.' "[3] Similarly, Daniel Hausman claims that "contemporary governments assign different goals to different sectors."[10] If understood as describing how health system administrators *do* make decisions, Goodin and Hausman may be correct. But their observations do not support the claim that administrators *should* make decisions this way.

What could support the claim that health ministries should focus only on health outcomes and ignore other outcomes? One argument for this would be the extension of Adam Smith's "invisible hand" argument—that the pursuit of disparate, individual interests by private firms and consumers ultimately serves the common good[14]—into the public sector. However, the factors that make invisible-hand reasoning work well in the private sector may not apply in the public sector. The case for competition among private-sector actors is that competition can "grow the pie," increasing the resources available to society as a whole. In contrast, competition between administrative agencies or ministries is often over a pie of resources whose size is fixed. Many contend that adversarial competition between agencies who each seek to maximize the achievement of their own goals takes society farther from realizing the best outcomes.[15]

To see how ministries reasoning in the way Goodin describes could create suboptimal outcomes, consider an example: introducing an invasive insectivore species could reduce the incidence of malaria, but would do so at a cost to ecosystems that is so high that (from a neutral perspective) it outweighs the gain in health. Goodin's imagined health ministry would order that the predator be introduced with no concern for its ecosystems. Meanwhile, the ministry responsible for environmental protection would spend its own money to eradicate the invasive species, without any concern for the malaria deaths caused by its actions. The waste of funds would be immense: agencies at such cross-purposes recall not Smith's invisible hand but rather O. Henry's *Gift of the Magi*, in which the husband sells his watch to buy his wife hair ornaments, while his wife sells her hair to buy him a

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watch-chain. Even having the ministry of health give only special, rather than exclusive, weight to health benefits would have similarly wasteful, albeit less drastic, consequences.

Further, even if invisible-hand principles can spur government to greater efficiency, these principles would not be best implemented by having different policy actors embrace disparate ends. Rather, returning to the distinction between ends and means, competition may be beneficial if policymakers employ disparate *means* with a view to best promoting the common good. Health policymakers, for instance, will develop proposals for employing health care to improve the common good; policymakers in education will suggest employing educational resources to do the same. Importantly, however, all policy actors will frame their proposals in terms of contribution to the same ultimate end.

Imperfect Information

What would a health policy that gave equal weight to indirect and non-health benefits look like? Brock worries that such a policy would be impractical to implement:

> Restricting benefit assessment to direct health benefits has the practical advantage of substantially limiting the scope of the assessment. Once we begin giving weight to the indirect non-health benefits of health interventions there is no obvious stopping point stretching out in time and in non-health domains beyond which we need not go. The more extensive the consequences to which we give weight the more tenuous and unreliable our estimations of them are likely to be. We risk soon finding ourselves giving significant weight in health care allocation and prioritization choices to effects whose nature, size, and probability are highly uncertain.[3]

We are skeptical that ignoring indirect and non-health benefits can claim the mantle of practicality. Even if easy measurability has some weight, what is measured cannot depart too far from what is actually valuable. It may be very difficult to organize nationwide voting or polling and very easy to take a poll of one's classroom: however, if our goal is ensuring that political decisions represent and serve the general public, a vote by 20 or 30 students—despite being easy—does a much worse job of achieving our actual goal. Even if accounting for indirect and non-health benefits is difficult, ignoring them will make it difficult for health policy to achieve desirable outcomes.

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If we are right, health policy needs to rest on a broader base of empirical evidence that takes account of the indirect and non-health effects of health policy interventions. This supports greater investment in policy evaluation. In the interim, however, some steps could be taken to improve the extent to which health policy considers non-health values. Many have argued for "health in all policies" initiatives, in which policymakers from non-health sectors are directed to consider the health effects of their proposals.[16] Such initiatives should be paired with similar "all policies in health" efforts, which empower health policymakers to consider the effects of their proposed policies on the distribution of non-health goods and give them the tools to assess those effects.

SPECIAL PROBLEMS IN THE DISTRIBUTION OF INDIRECT AND NON-HEALTH BENEFITS

Many distributive justice questions arise whether or not health policy takes indirect or non-health benefits into consideration. Because these issues are covered in Chapters 6, 11, and 17, we do not discuss distributive justice in general here. Rather, we focus specifically on distributive justice issues that arise if health policy considers indirect and non-health benefits in the priority-setting process. The three problems on which we focus are unfairness to the economically disadvantaged, the double counting of benefits, and disagreement regarding which non-health benefits are valuable.

Unfairness to the Economically Disadvantaged

Some may worry that considering indirect benefits will be unfair to economically disadvantaged people whose health could be improved if they receive direct health benefits. In her defense of prioritizing direct benefits, Kamm argues that considering indirect benefits is unjust because it denies treatment to some on the grounds that they are not a useful means to the good of others;[4] Brock makes similar arguments.[3]

We agree that it is undesirable to further burden the economically disadvantaged. Chapters 9 and 11 offer compelling arguments in support of this claim. However, consideration of one prominent category of indirect benefits is unlikely to impose disproportionate burdens on the economically disadvantaged. This category comprises benefits that are not downstream consequences of economic activity by the direct beneficiary, but are instead a side effect of the provision of treatment.[2] Examples of such benefits include the income obtained by the

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numerous individuals involved in health care provision (ranging from surgeons to administrative workers to janitors), the experience gained by those individuals, and the scientific knowledge gained through case reports. Considering these benefits would not disfavor the economically disadvantaged.

A different category of indirect benefits is more likely to implicate Kamm's concern about disadvantaging the already disadvantaged. This category comprises benefits "obtained by a third party as a result of the fact that the resource is given to a direct beneficiary," which du Toit and Millum illustrate using the example of dependent children who benefit indirectly from direct health benefits to their parents.[7] We will call this category "recipient-produced benefits." However, du Toit and Millum argue that, even if counting recipient-produced benefits to dependent children disadvantages the childless, not counting (or giving less weight to) such benefits fails to take proper account of children's interests. Similarly, even if counting recipient-produced benefits to a community from keeping a productive person alive disadvantages the unproductive, not counting those benefits at all ignores the interests of other individuals in the community, including those who may be disadvantaged. The defender of ignoring recipient-produced benefits, or giving them less weight, must explain why our responsibility to avoid ignoring those who are not useful is more important than our responsibility to help those who we can only help indirectly. Put another way, even if considering recipient-produced benefits may sometimes make it less likely that disadvantaged people will receive *direct* health benefits, considering recipient-produced benefits could improve their prospects of receiving benefits overall, by improving their prospects of receiving indirect benefits. We should always carefully assess the overall distributional impact of considering indirect benefits, and not merely assume that doing so hurts the disadvantaged.

As du Toit and Millum also observe, it is unclear whether considering recipient-produced benefits will systematically disadvantage those already badly off. For instance, consideration of recipient-produced benefits need not prioritize CEOs over ordinary workers, because many CEOs, though productive, are inessential—someone else could step into the CEO position with little loss of long-term productivity.

Lastly, sometimes the worst-off will be the most effective at generating recipient-produced benefits, because the marginal gain of benefiting the worst-off is greater: for instance, a reduction in copayments that improves the economic status of a poor worker by $1,000 may provide dramatically more benefit than improving the economic status of a wealthier individual by the same amount. Ultimately, counting non-health benefits need not compound disadvantage: the existence of any relationship is an empirical and contingent question.

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Double Counting and Comparison

It is important to ensure that the same benefits are not being double counted as both health and non-health benefits, nor are they being counted in more than one category of non-health benefit. For instance, previous versions of disability-adjusted life-year (DALY) approaches justified age weighting, in part on the basis that individuals at certain ages (in particular adulthood and middle age) do more to promote the flourishing of others in society than do individuals who are very young or very old.[17] When a metric includes both health and non-health benefits, as was previously true of DALYs, it is important not to double count non-health benefits, for instance by conducting an extended cost-effectiveness analysis that gives weight both to old-style DALYs and to productivity.

More generally, once health policy begins to consider benefits other than health, it must identify some methodology by which non-health benefits can be compared to health benefits. One common approach involves regarding health and non-health benefits as commensurable in terms of some foundational "currency" of value, such as well-being, resources, monetary wealth, or capabilities.[10] Others have offered procedures for setting priorities without commensurability.[18]

Disagreement

Most individuals believe that health is valuable, but disagree about the value of specific non-health benefits. For instance, some individuals and societies place higher priority on religious enlightenment, or access to the arts, than do others. As such, counting non-health benefits presents health policy with the problem of disagreement among citizens. One way of reducing such disagreements involves providing non-health benefits that are either all-purpose goods or widely agreed to be basic needs. All-purpose goods—goods that people want "whatever else they want"[19]—include income and wealth. Goods widely agreed to be human needs include goods like basic education, food, and shelter.

IMPLICATIONS

Economic Evaluation of Health Policy

Chapters 5 through 8 discuss four different approaches to the economic evaluation of health policy: cost-effectiveness analysis (CEA), extended cost-effectiveness analysis (ECEA), benefit-cost analysis (BCA), and the social welfare function (SWF) approach. Of these theories, BCA has the easiest time incorporating indirect and non-health benefits, since it converts all categories of benefit to a

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common currency, monetary value, before comparing them to costs. However, this ease comes with the challenge of securing agreement on the monetary value of benefits.

However, ECEA can also incorporate non-health benefits without converting them to a common currency if it includes non-health benefits as well as quality-adjusted life-years (QALYs) or DALYs in its evaluation of the benefits of an intervention. The challenge for ECEA is to determine which non-health benefits should be considered, and what priority to give different types of benefits.

Like ECEA, the SWF approach can incorporate non-health benefits by adding them to the "attribute bundle" against which a policy's effects on individuals are evaluated. Chapter 8 describes a SWF that includes only health, longevity, and income, as well as a more "ambitious" SWF that also includes other characteristics. The attributes considered are then combined into a utility function.

Traditional CEA will have the most difficult time incorporating non-health benefits. Indeed, a problem for traditional CEA is that if we consider *costs* (including non-health costs) when deciding which health interventions receive priority, it is difficult to see why we should not also consider non-health *benefits*. For instance, if reducing the incidence of a communicable disease through pesticide spraying costs $10,000 per QALY, while reducing it through a combination of environmental remediation plus spraying costs $12,000 per QALY but also produces an extra $4,000 worth of non-health benefits for each QALY saved (for instance, because the environmental remediation also improves agricultural productivity), it seems myopic to focus only on the higher overall costs of environmental remediation while ignoring its greater overall benefits. One possibility is that CEA could, as is often done, reframe forgone non-health benefits as opportunity costs of turning down other alternatives, although incorporating such opportunity costs into CEA threatens to break down the distinction between CEA and BCA.

Overall, the approach suggested in this chapter favors ECEA, BCA, or an ambitious SWF approach over traditional CEA approaches. While consequentialist, commensurability-based approaches like BCA are the most prominent way of integrating non-health and indirect benefits into priority-setting, it should also be possible to systematically integrate non-health and indirect benefits without reducing them to monetary values.

Health System Design and Financing

Consideration of indirect and non-health benefits will bear on the question of how health systems should be designed, in particular issues related to copayments and public finance. Eliminating or reducing copayments increases the cost of providing

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an intervention but can raise its non-health benefits by functioning as a monetary transfer that prevents poverty, thereby also indirectly improving the health of the beneficiary and of others. Apart from preventing poverty, the monetary transfer can also improve the financial status of health care recipients. It is important that ECEA approaches are clear about the value they assign to different indirect and non-health benefits (e.g., poverty prevention as opposed to prevention of monetary losses) of public financing of health care. Decision-makers then must consider whether they endorse this valuation.

Decisions about health care financing at the international level may also depend on how non-health and indirect benefits are considered. Publicly financing access to health care for people who are economically disadvantaged is more likely to produce certain non-health benefits, such as poverty prevention, and could therefore strengthen the case for global health aid to the economically disadvantaged. On the other hand, financing access to health care for people likely to be economically productive is an effective way of producing other non-health benefits, such as economic growth. This presents the question of whether and how international funders should consider non-health and indirect benefits when setting priorities among different nations that are potential recipients of funding.

CONCLUSION

Social and professional norms frequently lead individuals involved in the health care system, from patients to providers to policymakers, to adopt a tunnel-vision approach that attends only to one aspect of the health care system—the health benefits (and potential harms) directly experienced by patients because of health care interventions offered by providers. In contrast, the myriad other effects of the health care system are frequently ignored entirely, and generally given a much lower priority. The lack of empirical research that considers indirect and non-health benefits further encourages a tunnel-vision approach.

This chapter has argued that the tunnel-vision approach is mistaken. Health policy should ensure that its evidence base for interventions considers effects other than direct health effects, and should put more resources into conducting empirical studies that take a broad approach to social costs and benefits. Health policymakers should also collaborate with other policymakers in order to learn about and more effectively weigh the non-health impacts of health interventions. And they should be sensitive to normative issues that arise uniquely, or tend to arise more often, with non-health effects than within the domain of health. An approach to health policy that considers non-health benefits will more effectively

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improve the lives of the individuals it serves, whether by increasing health or improving its distribution.

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