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Social value judgments in healthcare: a philosophical critique

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Abstract

Purpose – The purpose of this paper is to consider some of the philosophical and bioethical issues raised by the creation of the draft social values framework developed to facilitate data collection and country-specific presentations at the inaugural workshop on "Social values and health priority setting" held in February 2011.

Design/methodology/approach – Conceptual analysis is used to analyse the term "social values", as employed in the framework, and its relationship to related ideas such as moral values. The structure of the framework (process and content values) is considered in light of current debate in philosophy and bioethics about the political and moral aims served by these kinds of values, and the extent to which they are either suited to, or sufficient for, the policy context.

Findings – There is much to be gained by engaging with the arguments presented in the philosophical literature in order to further refine the framework. The framework should remain neutral in respect of the importance of procedural values in different contexts and should be as inclusive as possible in respect of the principles it includes. Further development would be best served by taking a multidisciplinary approach. The framework could provide a valuable space in which future debates about procedural/substantive values can be considered.

Originality/value – The paper brings philosophical and bioethics perspectives to bear on a new framework proposed for the analysis of social values in health priority setting. It identifies how such a practical, policy-focused framework might be informed by engagement with deeper, and often unresolved, questions or principle around resource allocation in health.

Keywords Social values, Health care, Moral values, Bioethics, Philosophy, Health policy

Paper type General review

1. Introduction

The purpose of this brief review is to consider some philosophical and bioethical issues both behind the framework discussed at the initial Social Values and Health Priority Setting Workshop (Clark and Weale, 2012) and in priority setting more generally. There is, of course, a great deal of overlap between the wider literature and the social values framework (referred to henceforth as "the framework"), but there are also some additional issues and questions raised in philosophy and bioethics that have not been discussed. This review provides a starting point for considering whether the

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framework might be supplemented with insights from this literature, and underscores the need for representatives of different fields – such as moral philosophy, political science, bioethics, economics, law and medicine – to work together to ensure that the framework for priority-setting benefits maximally from their varying perspectives.

This review begins by looking first at how the term "social values" is used in the framework and how it is understood in the relevant philosophical literature, in contrast to related terms like "moral values". We then follow the structure of the initial framework in considering first what this literature has to say about procedural ("process") values and then about substantive ("content") values. The distinction drawn in the framework between these two classes of values, and the relationship between them, tracks an on-going debate in philosophy and bioethics about the political and moral aims served by these kinds of values and the extent to which either is suited to and sufficient for the policy context. Criticisms about the importance and adequacy of procedural values suggest that it may be important for the framework to remain neutral about whether procedural values should be the dominant normative component to priority-setting, as this is a hypothesis that the framework can evaluate as it is tested in different contexts. Similarly, debates about which substantive values are relevant and how they should be integrated and ordered suggest that it is important for the framework not to endorse one particular set of principles or values over another, but rather be structured so that it can incorporate a variety of morally relevant values and principles, which can then be balanced accordingly as the framework is employed in different contexts.

2. What are social values?

It is important to begin by clarifying the framework's intended definition of "social values", to avoid confusion with related ways in which we may encounter this term in the philosophical literature. For the purposes of the framework, "social values" might be defined as the values of the public or of society, including their moral values. This can be easily contrasted with a philosophical description of "moral values", which may (under some accounts), include values not necessarily held by a given society at a given time.

The attempt by the framework to include social values within priority setting processes reflects the view that moral values, and not only scientific and medical data or facts, play a central role in health priority-setting, and these values are those of society or "the public". The concern here relates to the justificatory force of priority setting decisions. The view taken by the framework is that, given the public are those most directly affected by priority setting, the framework should strive to incorporate values which are, broadly speaking, held by those to whom a justification is owed – even if gathering information about the public's values presents certain practical difficulties, especially when they form a complex and diverse set.

Given the definition of "social values" intended by the Social Values and Health Priority-Setting project, it is easy to understand why the initial framework places such a strong emphasis on procedural approaches to priority-setting; for there are some obvious ways in which procedural approaches incorporate social values into priority-setting decisions. For example, as discussed below, the framework stresses the importance of "participation" – that is, allowing members of the public and other stakeholders to participate in priority-setting decisions, thereby ensuring those

decisions track the public's moral values (or, at the least, the values of those members of the public who participate). One of the aims of this paper, though, is to stress that a commitment to social values does not, in itself, imply that procedural approaches to priority-setting should be more dominant than approaches relying upon substantive principles. Rather, these two approaches to priority-setting form a complex, interconnected whole.

In the remainder of this piece, we consider some salient issues in philosophical discussions of both procedural and substantive approaches to priority-setting, and highlight some implications of our discussion for the initial framework.

3. Procedural values

In moral and political philosophy, considerations of process or procedure are generally introduced in discussions of the legitimacy of political structures. Democratic processes such as voting, for example, allow individual citizens to express their preferences for and against particular aspects of government, thereby contributing to the legitimacy of the political structures that are eventually agreed upon, and the decisions made within them. The framework identifies three specific procedural values it takes to be importantly connected to the legitimacy of priority-setting decisions: accountability, transparency and participation.

The philosophical work on procedural values and priority-setting has been heavily influenced by Daniels' and Sabin's work on "Accountability for reasonableness". This approach grew out of Daniels' Rawlsian theory of justice and health that, as Daniels acknowledged, provided little practical guidance on questions of how to allocate scarce resources, despite helping to clarify some important theoretical issues about health inequality. In the absence of societal consensus about principles for resolving disagreements about rationing, Daniels suggests that a "fair process" is needed to ensure that priority-setting decisions are legitimate and fair (Daniels, 2000, p. 1300). According to Daniels, this process should include the following elements:

- transparency about the grounds for a decision;
- appeals to rationales that all can accept as meeting health needs;
- procedures for revising decisions in light of challenges and appeals; and
- methods of enforcement.

Two of the three procedural values incorporated into the framework are present in Daniels' and Sabin's approach: transparency is met through the requirement that reasons behind decisions be made public and accountability is met through the requirements that the procedures be regulated and enforced and include opportunities for appeal and revision.

There is much to be commended about the attempt to ground priority-setting decisions on considerations of procedural justice. There is little doubt that values such as transparency, accountability and participation enhance the perceived legitimacy of such decisions, and that greater public awareness of the grounds for decision-making is an important step towards ensuring there is greater public understanding of the various constraints on decision-making that exist. But a number of concerns have been raised about the limits of the procedural approach, and it is important to bear these in mind when putting forward a framework for priority-setting. These concerns can be

grouped into three categories: concerns that procedural values might be emphasised at the expense of substantive values; concerns about the practical and cultural effectiveness of procedural values in improving priority-setting; concerns about the specific values of "accountability", "transparency" and "participation".

3.1 Process over content?

Daniels notes that "establishing a fair process for priority-setting is easier than agreeing on principles" (ibid.). This may well be true. But the ease with which processes can be established obviously should not lead to the complacent view that procedure alone can ensure the fairness of priority-setting decisions. Whilst procedural values might be necessary for the legitimacy of priority-setting decisions, they are clearly not sufficient. Unless other moral constraints are brought to bear on priority-setting decisions – constraints that inevitably bring us into contact with substantive values (see below) – procedural values alone are insufficient from a normative standpoint. Procedural values often seem to presuppose substantive values and, as Powers and Faden have pointed out (Powers and Faden, 2008, p. 184), institutional decision makers are still in the end required to make hard decisions that cannot be fully determined by procedural values. By giving procedural values high priority, there is also the danger that other normative considerations are not discussed at the level and depth needed to justify their adoption.

As such, it seems reasonable to conclude that, even if some procedural values may be necessary for the legitimacy of priority-setting decisions – say, by making the substantive principles of decision-makers transparent or helping to narrow the range of morally permissible options – they should not necessarily have normative priority over substantive values (for similar concerns, see Friedman, 2008, pp. 101-112; Persad *et al.*, 2009, p. 429; Kerstein and Bognar, 2010, p. 43; and Johri and Norheim, 2009, p. 22).

3.2 Practical and cultural concerns about procedural values

In addition to the concern that procedural values might be emphasised at the expense of substantive values, there are further, practical and cultural questions to bear in mind. Of central concern in light of the scope of the social values and priority-setting project is whether all countries and cultures value procedural approaches in the same way. Can fair priority-setting decisions be reached in contexts where procedural values are not considered to be particularly important or necessary? A recent study of priority-setting in eight different countries notes that many countries without widespread public involvement in decision-making have achieved priority-setting objectives that are largely accepted by the public (Sabik and Lie, 2008).

In Norway, for example, "the recommendation was that this process [of decision-making] should be expert-driven, and not involve much public debate". The study suggests that in many countries "an expert-led process may be accepted by the general public", and whilst this does not show that there should be no public involvement whatsoever in decision-making, or that procedural values are unimportant, it does call into question a prevalent assumption in priority-setting literature that public involvement is an essential component of decision-making.

Another practical consideration is that many priority-setting decisions need to be made quickly, when it may not be possible to go through the proper processes of transparency, accountability and participation. For example, Arras notes that in

pandemic situations there are likely to be many empirical uncertainties that cannot be worked out and agreed upon in advance (e.g. the virulence of the disease, the extent to which it may affect different sections of the population, and so on). This means that "previously agreed rationing strategies" may well have to be altered at short notice by public health officials (Arras, 2005, pp. 297-298). In these kinds of situations, it would seem strange to suggest that such actions would be unjust simply because they had not been reached through the proper processes.

3.3 Clarification of procedural values

The final set of concerns raised about procedural values regards the definition of and balance between the specific values discussed. As noted above, the framework incorporates three values: accountability, transparency and participation. It is worth considering each of these values in more detail, and some possible problems that may arise when considering how best to incorporate them into decision-making frameworks.

In consideration of the value of accountability, some concerns have been raised about the ways in which demands for accountability might be too stringent or heavily regulated. As O'Neill notes, excessive regulation may only ensure "accountability to regulators" rather than true accountability to the public. She also suggests that too strong an emphasis on accountability might create counter-productive outcomes, obstructing the ability of professionals to carry out their work effectively as they face demands to record details and meet targets for performance (O'Neill, 2002). Although there is no evidence to suggest this is happening in the context of health priority-setting, such doubts about the value of accountability raise two important issues: first, there is a question about the mismatch between popular "rhetoric" about the so-called "accountability revolution" and the ways in which, in practice, targets for accountability should be met. It is important that discussions of procedural values in priority-setting contexts steer away from empty rhetoric about accountability, and set clear and achievable processes for holding individuals to account for their decisions. Second, some of the concerns raised about accountability can be mitigated if accountability is seen as one among various important values that should shape and guide priority-setting, rather than a procedural value that somehow guarantees fair outcomes to decision-making. This means that, provided the first set of concerns considered above (3.1) are taken seriously, there is good reason to think that excessive demands for accountability would not be made at the expense of other substantive values.

In consideration of the value of transparency, O'Neill makes the important point that mere disclosure of information does not ensure that it will be intelligible to the public – mere publicity, that is, may simply provide a "flood of information", causing a great deal of uncertainty in the public mindset (O'Neill, 2002). This point is also made by Rid, who argues that the publicity condition for procedural justice in priority-setting contexts should be expanded to ensure greater public awareness, requiring active communication with the public rather than mere disclosure (Rid, 2009, p. 16). O'Neill also suggests that there is an important connection between transparency and accountability, and notes that individuals should be able to trace pieces of information to their various sources, enabling them to actively make judgements about the information they assess, rather than simply passively receiving it.

Finally, as Clark and Weale (2012) point out, the value of participation raises challenging questions about how best to capture what is morally and politically important about engaging the public and other stakeholders in priority setting decisions. Just as there is no single set of public moral values about health care, there is no single set of persons who can be taken to represent the values of the public. Questions remain about the legitimacy of whatever approach to participation is adopted, not only about whose values should be engaged but also about what methods best capture what the range of relevant values actually is. For example, deliberative approaches stress the importance of eliciting the reflective and informed values of public participants (Mitton *et al.*, 2009; Fishkin, 2009), while various traditional social science methods stress the importance of eliciting reproducible findings about relevant values and priority setting tradeoffs from large numbers of people (Arnold *et al.*, 2009; Nord *et al.*, 2009; Ubel, 1999; Dolan and Cookson, 1998). Questions of legitimate representation emerge as well when members of the public are appointed to priority setting bodies and when public advisory committees are established to provide guidance to policy makers on social values and priority setting. These considerations need to be borne in mind when thinking about the importance of participation in priority-setting contexts.

3.4 Procedural values: conclusions

The philosophical literature on procedural values has raised some scepticism about the importance of procedural values to priority-setting – at least to the extent that procedural values should not be given such high prominence as is often the case in these discussions. In addition, there are important practical considerations to bear in mind about the extent to which, in practice, procedural values are viewed as important to decision-making (particularly in countries that make priority-setting decisions without them), and their inability to provide guidance in situations of medical urgency. Finally, there is a need to be specific about exactly how to define and balance values of accountability, transparency and participation – moving away from some of the popular rhetoric surrounding these values – and to be aware of the various senses in which they overlap.

In light of these considerations, we might recommend two changes to the initial framework: first, there is a need to be clearer about the various ways in which the procedural values under consideration overlap. Second, the framework should proceed with caution when giving specific endorsements of procedural values – particularly in light of the ways in which the importance attached to procedural values might vary according to country and context. Whilst there is little doubt that these values should be part of the framework, one purpose of the framework might be to test various hypotheses about the importance of and need for specific procedural values. It may be that empirical case studies confirm the scepticism expressed above, or they may provide evidence for a more positive conclusion. Either way, it is important the framework provides a neutral platform for considering the importance of procedural values in different contexts, without stating in advance whether these should be given particular normative priority in decision-making contexts.

4. Substantive values: towards a multi-principle framework

One alternative to constructing a decision-making framework around procedural values is to ground decision-making in a set of substantive values and principles. The thought here is that the fairness and legitimacy of a decision will be guaranteed not by the procedures by which it was reached and implemented but the extent to which it accords with an appropriate set of specified values.

Substantive approaches to making decisions about priorities – just like procedural approaches – face a number of challenges, some of which are noted in the social values and health priority-setting framework paper (Clark and Weale, 2012). The framework identifies five "content" values: clinical effectiveness, cost effectiveness, justice/equity, solidarity and autonomy. In the philosophical and bioethics literature on priority setting, justice is generally put forward as the dominant substantive principle. Competing accounts of justice differ in the extent to which they are inclusive of values like clinical and cost effectiveness, solidarity, and respect for autonomy; depending on the specific priority setting context, these accounts may offer more or less guidance (Daniels, 2008; Powers and Faden, 2008). Important puzzles currently unresolved in the philosophical literature include:

(1) What are the relevant goods to attend to when setting priorities in healthcare?

(2) What constitutes a just distribution of goods across a population?

(3) If we take multiple goods or distributions to bear some sort of value, how can we best balance their competing claims against one another or resolve conflicts between them?

In what follows, we consider each of these questions.

4.1 What are the relevant goods to attend to when setting priorities in healthcare?

The first question that needs to be resolved when considering how to allocate health care resources is the nature of the good, or the sorts of goods, that we are trying to achieve or advance by way of the allocation. Instinctively we might feel that the answer to this question is straightforward: the good at issue is health, whether the health of individuals or of populations. However, this answer only leads to further questions. For example, how should we define the good of health? That is, what sorts of goods should we include as goods of health as opposed to other types of goods? Working definitions used by the World Health Organisation emphasise the notion of human well-being to define health goods (WHO, 2012); yet this can lead to further difficult questions. For example, assuming confidence in how one looks counts towards one's well-being, does that mean surgical or dermatological resources should be used to improve our appearance? In answering this, does it make a difference whether we are only using such healthcare resources to correct or prevent the effects of acne, or the results of an injury or fire? Our responses to these sorts of questions may pull apart, either because of disagreements about what counts as a health benefit, or about the kinds of health benefits that should be considered when allocating healthcare resources. There are also questions about whether goods other than health should be considered in allocating healthcare resources. For example, the goods of attachment and affiliation may support allocating resources to allow parents to stay in hospital

with their ill children, even if the presence of parents does not improve children's health outcomes (Powers and Faden, 2008).

4.1.1 Health benefits as QALYs. In the literature around priority setting, these vexing questions are often side stepped. It is assumed that health is the good to be advanced by the allocation, and that what counts as a health benefit can, for purposes of allocation, be adequately captured by the metric of a quality-adjusted life-year or QALY. Hence, commentators will often discuss how to maximise health benefits for a population given a set level of resources in terms of how to maximise that population's QALYs.

As short hand for "health benefits", the QALY has some important advantages. Most importantly, it draws on two intuitions about what constitutes a healthy life: namely, a life lived free of disability and or suffering and one lived as long as possible.

Taking QALYs as a proxy for the good sought by healthcare, though, presents certain problems. For example, one widely discussed issue in the concerns the extent to which QALYs reflect our intuitions about the relative importance of life years over the course of our lives. In its traditional form, the QALY place the same value on a year of life regardless of when that year is lived. However, many feel that this fails to respect a widespread view across all age groups that the value of an extra year of life means more to the young than to the old, or, to put it another way, that the value of life-years diminish after one reaches a given age. This argument plays on the "fair innings" argument noted by Clark and Weale (2012) namely that what matters in healthcare is not necessarily prolonging people's life but ensuring that each person has a reasonably long and healthy life, that is, a "fair innings" (see Harris, 1986; Williams, 1997, pp. 117-132).

Perhaps more worrying from a philosophical point of view is that understanding health benefits in terms of QALYs does not take us much further in our attempt to articulate the dimensions of health we are trying to achieve when setting priorities in health care. For example, although the QALY respects the importance we place on "quality of life", we are still left debating precisely what this "quality of life" consists in. Traditionally, economists adopting a QALY methodology have measured quality of life using EuroQols five dimension scale of health (EQ-5D); the five dimensions being "mobility", "self-care", "usual-activities", "pain/discomfort", and "anxiety/depression". However, following numerous criticisms of this scale and similar attempts to develop measures of health outcomes or states of health, some writers, partly inspired by Amartya Sen (Sen, 1985), have suggested that healthcare systems should aim, at least in part, towards improving people's capabilities to pursue what it is about health or other aspects of well-being that they have reason to value (attempts to develop capability accounts of health include efforts by Anand, 2005a, b; Anand and Dolan, 2005, pp. 219-222; Coast *et al.*, 2008, pp. 667-670; Cookson, 2005a, p. 14, pp. 817-829 and p. 59; Cookson, 2005b, pp. 1287-1289; Hausman, 2008, pp. 79-83; Ruger, 2006).

4.1.2 Wider societal objectives. In addition to the securing of health benefits for individuals and populations, some commentators have also suggested that one should consider the extent to which the provision of a service has instrumental value in the furtherance of other societal goods or goals when setting priorities (in this sense, in the philosophical literature, a "social value judgment" usually refers to a judgment made on grounds of instrumental value or the promotion of specifically social goals, rather than the use intended by the framework discussed in this collection of papers). For

example, numerous countries and commentators have taken the position that the goal of narrowing unjust inequalities in health and well-being between advantaged and disadvantaged groups is a legitimate independent objective for health care systems (Department of Health, 2010; Anand, 2004, pp. 15-20; Powers and Faden, 2008). Alternatively, some have argued that the provision of relief to carers of people with disabilities is also an important objective that should be included in priority setting decisions, as is reducing missed days of work, or permitting parents to stay in hospital with their ill children, even if there are additional costs and no additional improvements in children's health outcomes.

More contentions are claims that when setting priorities we should consider the "irreplaceability" to society of some individuals over others (Langford, 1992, pp. 9-17). This idea has been challenged on the basis that it fails to recognise the intrinsic value and dignity of human beings, instead, evaluating individuals and their health state, purely in terms of their instrumental value to society's needs and goals. For this reason, the "social worth" consideration is generally only raised in cases of extreme scarcity, such as pandemics, other natural disasters and warzones, where compelling justification for its limited applicability can sometimes be advanced (Arras, 2005, p. 293).

4.2 What constitutes a just distribution of goods across a population?

Another set of questions concerns how to justly distribute the goods of health care across a population. Here again we are led into areas of extensive debate within political philosophy. In terms of the philosophical literature on priority setting, much of the discussion has centred on egalitarian alternatives to utilitarian approaches.

4.2.1 Utilitarian approaches. Utilitarianism, put simply, is the view that society should aim to maximise the utility of individuals, aiming for "the greatest happiness of the greatest number". Assuming that in the case of healthcare the good to be realised is population health and that QALYs are an appropriate metric for that outcome, utilitarian approaches to priority setting would normally ascribe to something like the following principle: all distributive questions should be settled according to which distribution maximises the number of QALYs across a given population.

The main appeal of using utilitarian principles to guide resource allocation decisions is that they meet considerations of efficiency and beneficence. Resources are used in the most optimal way by prioritising those most interventions that are to produce the most health benefit per resource invested. However, using utilitarian principles in isolation may also lead to outcomes we may find undesirable. For example, following utilitarian principles may lead one to prioritise those with the greatest capacity to benefit from treatment, at the cost of those who's capacity to benefit is low; leading, in the eyes of some, to a form of discrimination (Harris, 1987, pp. 117-123). Similarly, it is common criticism that distributions that aim to maximise total health benefit ignore, or even make worse off, those who are already badly off.

4.2.2 Egalitarian approaches. Partly in response to the deficiencies of utilitarian principles, many commentators have advocated more egalitarian approaches, often building on the foundational work of John Rawls. There are a few models to choose from here.

One egalitarian approach to resource distribution is inspired by the maximin principle, famously put forward by Rawls (Rawls, 1971). According to the maximin

principle, one should distribute resources so as to benefit the worst off 1. Such a system is egalitarian in the sense that it implies a person's right to resources is first dependent upon the extent to which such an allocation contributes to a more equal distribution of health states (hence the priority given to the worst off). However, setting health care priorities in this way can be both problematic and difficult. For example, Kerstein and Bognar contest distributions of the sought implied by the maximin principle on the basis that it discriminates between patients in precisely the same way as utilitarian approaches do, unfairly prioritising those in the greatest need over others. As they put it, it would be "invidious" for a health system to refuse treatment to a person in pain purely on the basis they are considered "too well off overall", which is to say, well-off in comparison to other patients (Kerstein and Bognar, 2010, p. 38).

In a crude way, one can identify egalitarian thinking behind ideas such as the "rule of rescue". According to the rule of rescue, one should distribute resources to in such a way that prioritises those in immediate peril, and thus, on one reading, those who are worst off. However, as Persad *et al.* explain, using the rule of rescue to allocate healthcare resources alone may be "inherently flawed" because it prioritises the acutely ill over those who are currently less ill but whose condition is likely to become just as acute.

One approach to resource distribution that avoids this kind of problem is a "lottery" system of allocation (see e.g. Langford, 1992, p. 13; and Persad *et al.*, 2009, pp. 423-424). Lottery systems are egalitarian in that they reflect the idea that all individuals have an equal claim to scarce resources. As Harris puts it, a lottery system incorporates the principle that "each person's desire to say alive should be regarded as of the same importance and deserving the same respect as that of anyone else" (Harris, 1986).

By allocating resources "equally", the lottery system responds to the kinds of worries about discrimination implicit in both utilitarian and maximin approaches and maybe appropriate for certain allocation contexts. However, as is widely recognised, the appeal of the lottery also comes at a high cost, namely by failing to capture either the intuitions behind utilitarianism or other forms of egalitarianism.

4.3 How can we resolve conflicts between the competing claims of different goods and distributions?

Perhaps the main thing to emerge from this brief review of the kinds of debates surrounding the use of substantive values is the extent to which our intuitions about what is fair or just, or what constitutes the appropriate ends for health care systems, tend to pull us in different directions. For this reason, rather than defending one principle or value at the exclusion of all others, many writers have concluded that we must be ready to hold a plurality of substantive values when making decisions about resource allocation (Persad *et al.*, 2009; Cookson and Dolan, 2000).

Accepting this kind of pluralism about substantive values, though, can lead us into further difficulties. In particular, it can be extremely difficult to resolve conflicts between the competing claims of different values. Say, for example, we wish to decide how to allocate resources between an intensive care unit and an anti-smoking campaign. From a utilitarian perspective, we may be inclined to support the anti-smoking campaign, on the basis that this is most likely to maximise health-benefits (at least, for the sake of this argument). However, from an egalitarian perspective, we may be inclined to support the intensive care unit, on the basis that it

prioritises the worst off or those in greatest need. If we accept, though, that both our utilitarian intuitions and our egalitarian intuitions are both legitimate, we are left in the unenviable position of having to decide between them, or reflecting on which has more "weight" or "pull" in this particular instance. Once we bring into consideration other values, such as personal responsibility for health condition, or social benefit and so on, this decision only becomes more complicated.

Writers have responded to this problem in a number of ways. One particularly prevalent approach in the economic literature is to resolve conflicts between different values by assigning weights to different considerations on the basis of popular opinion – essentially canvassing opinions on what society deems "most important". This system lends a welcome democratic element to resource allocation decisions, yet, as is widely recognised, it also faces significant methodological and political obstacles (Powers and Faden, 2008).

The ethical literature around these sorts of questions provides a variety of further possibilities. Some writers, though not many, advocate a simple lexical ranking of the principles. Following such a system, in any given system, the "right thing to do" is established simply by the principle or value ranked the highest. Another suggestion is to weight principles following philosophical reflection (Ross, 1930). This suggestion differs from a straightforward ranking of principles; for while in the first case, a lexically superior principle can never be defeated, in the second, a weightier principle can be defeated by a combination of individually less weighty ones. Scanlon suggests a third possibility. Working from the assumption that there are no actual conflicts between valid ethical principles but only apparent ones, Scanlon claims all such conflicts can be resolved by further specifying the content principle in question (Scanlon, 1998; see Dancy, 2004, for a detailed objection to Scanlon's view).

One final possibility, particularly pertinent in respect of the framework laid out in this collection, is that a plurality of values implies not one right answer but a number of legitimate distributions. Since there is reason to think that allocation systems should be sensitive to the specific contexts to which they are applied – especially if they are applied across a variety of countries – there may well be advantages to such a view.

4.4 Substantive values: conclusions

This brief discussion of substantive values has drawn attention to some principles of allocation often discussed in the literature. It has emphasised the importance of attempting to put forward pluralistic, multi-principle systems of allocation, allowing different allocation decisions to be reached in different contexts. Although a much fuller discussion of the various principles outlined above is needed (and more principles might well be introduced), it is promising to think that allocation frameworks can take into account a wide variety of morally relevant principles, and the social values framework should be as inclusive as possible when considering which principles it might incorporate. The importance of and relationship between these principles might then be tested across a variety of contexts and case studies, to see if there is any convergence about how they might be balanced in particular situations.

5. Conclusion

From this brief review of the philosophical and bioethical literature, it is clear that the social values framework is situated within a multitude of on-going debates about how

best to ensure priority setting decisions are made fairly and in a justifiable manner. There may be the temptation to shy away from these deeper questions; especially as so many remain unresolved. However, there is much to be gained by engaging with the arguments presented in the philosophical literature; for it is through such engagement that the framework may be further refined. For example, as we have seen, following arguments presented on a purely theoretical level, one can reasonably conclude that the framework should remain neutral in respect to the importance of procedural values in different contexts; moreover, that it should not necessarily give normative priority to procedural approaches over substantive principles, and should be as inclusive as possible in respect of the principles it might seek to encompass. Importantly, this relationship between the framework and disciplines such as moral philosophy and bioethics is reciprocal. For, in turn, the framework makes clear the need for philosophers to articulate the kinds of social values that should be included in any priority setting process and, perhaps more importantly, provides a space in which future debates about procedural/substantive values can play out and – hopefully – be resolved.

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