Author's response to reviews

Title: Health, Well-Being, and Measuring the Burden of Disease

Authors:

Daniel M Hausman (dhausman@wisc.edu)

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Author's response to reviews: see over
Dear Josh,

Thanks for the comments, which were very helpful. My responses are interspersed in red.

In addition to responding to all your suggestions and improving the prose, I realized that my exposition of Broome's first argument and my adaptation of it in the paper was not nearly as clear as it should have been, and pages 3 – 5 consequently contain extensive rewriting. I also slightly changed the title.

In any event, all the changes are tracked, as the editor requested.

All best, Dan

Comments on Hausman’s “Health, Well-Being and the Burden of Disease”

First, one formatting point and a small point about attribution:

1. I don’t believe that PHM allows for footnotes. The material in these footnotes will therefore need to be incorporated into the text. .footnotes eliminated
2. I believe that the attribution of ideas to “WHO staff” and “IHME staff” is a bit too coarse. On the one hand it may imply an institutional endorsement that might be controversial in the case of “WHO staff”. On the other it defines too narrowly the participation in the latest GBD in the case of “IHME staff”, as the current revision of the GBD is being led by a core team drawn from five institutions: IHME, WHO, Harvard, Hopkins and Queensland. So I think some rewording is needed for all these references to “WHO and IHME staff.” Perhaps a reasonable shorthand would refer simply to the “Global Burden of Disease” team, or something like that. .reworked, largely following your suggestion

Now, on to a few substantive comments. I will confine these comments to points of editorial clarification rather than comments on or responses to the argument put forward in the paper, as I think the place for the latter will be in the discussions that I hope this review will motivate.

1. P.2, “change in the distribution of health states.” It may be more accurate to say that the burden of disease measures the distance between an existing distribution of health states and an idealized one in which everybody in the population is in the best health state (allowing for some ambiguity in one the “best health state” implies). This is a subtle distinction but an important one, because the burden of disease, at least in its main form of output, does not answer the counterfactual question of how population health changes due to disease, but rather follows the tradition of categorical attribution of a current distribution to a set of mutually exclusive and collectively exhaustive causes. .fixed
2. P.2 "There is no way to make a quantitative comparison..." You may not agree, but it seems to me it would be more apt to qualify this by saying "no way to make an unambiguous comparison". We disagree here, and in a brief paper I cannot present a full-scale argument for this conclusion. But I did add a few sentences defending my claim.

3. "Hausman unpublished": has status changed on this one? Yes it has and the citation has been changed.

4. P.3 RE: Broome assertion on separability. Later you say that you agree with much of Broome’s argument except for the one about the need to measure harm done in terms of all of well-being. I couldn’t tell if you agree with the assertion on separability of health and non-health components of well-being or not. My central point is a generalization of his claim about the inseparability of welfare consequences, as is now (I hope) clear.

5. P.6, “For example, findings concerning the consequences of a disease for mortality in different age groups... helps policy makers to estimate the effects of the proposed public health plans on well-being without itself saying anything about well-being.” I am a little confused by what argument you are making here. Can you make this more precise? The passage has been revised and simplified.

6. P.8, You make an important distinction between the relative amenability of health vs. well-being to adaptation. I would like to see a little more elaboration of this argument. Are you asserting, for example, that well-being may be more amenable than health to improvement via adaptation? If so, should we understand this phenomenon in terms of other non-health aspects of well-being improving (more than health aspects) in order to compensate for decrements in health elements of well-being? Though I kept the discussion brief, I think I’ve made it more pointed.

7. P.9, On a point somewhat related to the previous one, do you conceptualize dimensions of health as comprising a subset of the broader set of dimensions of well-being? If so, the wording "people are concerned specifically about health, not just well-being" confuses a bit, as it seems to imply that well-being is contained inside of the broader construct of health, rather than the reverse. Later when you say that “what constitutes a person’s good is even more multidimensional than what constitutes their health” I inferred that your view was consistent with the notion of health as a subset of well-being. Given the length limit I cannot develop or defend a view of health in this essay, and I did not mean to embed the n dimensions of health within the n + m dimensions of well-being. I changed wording to help avoid suggesting this and to avoid the inverse suggestion that well-being might somehow be contained within the dimensions of health.

8. P.10 “Though one might reasonably expect them to be able to estimate the effects of diseases or policies on health,...” Do you mean to say, “on the distribution of health states”? Yes.

A couple of minor editorial points.
p.1, toward the bottom: “sequence of their health states” does not agree with singular “a person’s health”. fixed
p.2, toward the bottom: “the WHO” should be just WHO. reworded
P.14, Footnote g ends abruptly. footnote eliminated and passage repaired.