

Health Care and Justice

1. The Problem. The American health care system is, by general agreement, in pretty bad shape. Putting aside many relevant details, there are two basic facts about it that trouble observers.

First, the United States spends a vast quantity of money each year on health care, much more than the amount spent in other comparably wealthy countries. The United States spends nearly two-and-a-half times the median per capita spending in the industrial world (see Gladwell, WHO report for 1998); as a percentage of GDP, the United States now spends more than 60% above the OECD median.

Of course, if we are spending more and getting more, you might conclude that we simply have a cultural preference for greater health, and are prepared to spend what we need to achieve it. But, and here we come to the second basic fact, health outcomes in the United States are relatively poor by comparison with countries that spend much less. In 2000, for example, the United States ranked 23rd in the world for male and female life expectancy. And as for infant mortality: the United States now ranks 19th in the world, and considerably higher than any OECD country: moreover, the black infant mortality rate is twice the rate for white Americans. We also have a poor score of what is called “disability-adjusted life expectancy” (the number of healthy years that we can expect on average): here, the United States was (in 1998) 24th in the world. So it appears as if we are now getting very much for our money.

Something has gone wrong, and, while health is not simply a product of health care, at least part of the story has to do with the now-45 million Americans who have no health insurance, and therefore have limited access to health care: uninsured Americans are nearly eight times more likely than Americans with private health insurance to skip health care because they cannot afford it. Not surprisingly, lack of insurance is particularly common among low-income Americans: 68% of low-income adults were insured for at least part of the time between 1996-99. Others are covered by a vastly complicated system of private insurers with very high levels of administrative overhead (20-25% of total expenditures).

In discussions of health care, then, it is common to worry both about the sheer amount that we are spending, and about the distribution of health care and of health itself. These concerns about the US system are widespread, though they have resisted remedy over a very long period—there were major reform efforts during the presidencies of Roosevelt, Truman, Nixon, and Clinton—and there is considerable disagreement about how to fix the health care system. Some reformers favor a “single payer” system in which universal coverage is achieved through a national basic health insurance plan, which can be supplemented with additional private insurance; an alternative, suggested by Emanuel and Fuchs, is a universal system in which we all get a voucher that we can use to pay for basic health services or health insurance from a qualified provider. This plan, they argue, has a better fit with American political values—of liberty and equality—than proposals that provide less room for individual choice,

either in medical providers or in insurance systems. Other proposals—to rely more on health savings accounts, for example—put even more weight on individual decisions, requiring individuals to pay for routine expenses out of a tax-free savings account, and to buy insurance with large deductibles.

2. Two Values. Now this course is not about public policy, though issues of policy come before us—education, labor market regulation, health care—because they implicate and illustrate the issues of justice that do concern us. And, as the Emanuel and Fuchs argument indicates, the case of health care implicates two large issues that have been a focus of our attention: issues about individual choice and equality.

First, a concern with responsible choice by individuals. In different ways, Mill, Nozick, Friedman, and Dworkin all emphasize the importance of individual responsibility: each embraces the anti-paternalistic idea that individuals, in Dworkin's strong formulation, have ultimate responsibility for the success of their own lives. As applied to the case of health and health care, the implications of this idea are controversial, but some people might argue (indeed some do argue) that a concern about individual responsibility should make us wary about a system that provides comprehensive health insurance for all. Individuals, they might say, should make efforts to ensure that they are healthy, and they should decide how much health insurance to purchase, as part of a strategy of taking care of themselves. To be sure, we might have some basic package for everyone—or provide some financial incentives, say in the form of tax benefits

for people who save to pay for their health care). But the design should ensure that individuals use some of their own resources to pay health care costs.

Part of the reason for this requirement that individuals act as the responsible agents of their own health arises out of a concern about the moral importance of responsibility. And partly there is an issue, the seriousness of which is a matter of disagreement among different analysts (as Gladwell observes), about the efficient allocation of resources to health care. Insurance, according to this argument, in effect drops the cost of using health care to zero, so demand for health care is too high. Here we have what is called a problem of “moral hazard”: as a general matter, if people are not required to cover their own costs, they will be less careful, more likely to cause damage, and to externalize those costs. Auto insurance makes drivers less cautious; fire insurance make home owners less careful. And health insurance makes people less worried about their health in the first place, and more inclined to spend time with doctors and in hospitals than they would otherwise be.

The precise force of this concern with the bad incentive effects of insurance is a matter of some disagreement. Of course it is true that health insurance increases the demand for medical services. Part of the point of the health insurance is to enable people to obtain medical services that they would otherwise be unable to obtain. The issue is whether people use the insurance to “overconsume”: do they spend more time with doctors and in hospitals than they would spend if you gave them the money instead of paying their bills? And the answer to that question is not so clear. After all, most people do not like to spend

time in hospitals or with doctors, and we do not have to worry about people overconsuming coronary bypass surgery, or chemotherapy, or radiation treatments, or getting fillings or crowns for teeth: most people see doctors because they are having a health problem. So there may be substantial limits on consumption in this area that come from the nature of the goods, and the moral hazard issue may be overrated. Still, there may be some concern, and Dworkin, who thinks that there ought to be a generous scheme of health care, allows that real troubles may arise from the fact that “health insurance makes patients insensitive to cost at the moment of decision.”

The second concern is about equality. Ordinarily, when we hold someone responsible for doing something, the assignment of responsibility assumes that we have done our part. It is hard to complain about people failing to pay their taxes, for example, when lots of others are failing to pay, or when the revenues are being spent for deeply misguided reasons. Applied to the case of health care and health insurance: if we say that individuals are responsible for taking care of their health, and should not be blaming others—or insisting that others pay the bills—when their health is poor, as when other things in life go badly, we need to be sure that we have done our part. And what is that part?

The beginning of an answer to this question is that health care seems to be a special good: being healthy is neither a goal—like becoming a scientist or scholar or engineer or craftsman or good parent—nor is it a standard means for achieving goals, like money or a safe transportation or decent clothes. It is more like an essential precondition for leading a successful life, and for having access

to the range of opportunities that others have as well. And because it is such a basic good, so important to being able to make decisions about what kind of life to lead, there is natural resistance to the idea that access to health care should be distributed according to money, rather than according to the need for care. Even those who favor less broad and sweeping health care coverage—and insist on a large role for personal responsibility—acknowledge that there is something special about ensuring access to health care: that we owe something others in this domain, that they have a claim on us, and that we ought not to be pressing the issue of personal responsibility unless we have discharged that collective responsibility.

One way to get a handle on this issue about collective responsibility is to think that health problems are in part a matter of brute bad luck. In reference to the sharing of risks that comes with universal health insurance, Gladwell says that the merits of the system comes down to this: “do you think that this kind of redistribution of risk is a good idea? Do you think that people whose genes predispose them to depression or cancer, of whose poverty complicates asthma or diabetes, or who get hit by a drunk driver, or who have to keep their mouths closed because their teeth are rotting ought to bear a greater share of the costs of their health care than those of us *who are lucky enough to escape such misfortunes?*”

This is a powerful question, but Gladwell misstates its force in two ways. He says first that the idea behind sharing the risks of this bad luck is that individuals are prepared to pay for the risks that others face in order to be sure

that his/her own risks are covered. But if the point is simply prudent risk-pooling why not find other low-risk people to pool with, rather than pooling with all the high-risk people? And he says—in a utilitarian spirit—that coverage for everyone makes “the population as a whole” better off. That may be true, but there is another rationale for sharing risks with others, suggested by seeing someone who is suffering from a health problem and thinking: “there but for the grace of God go I.”

Now it may be misleading to think that, literally, you could have suffered from the same problem. In the case of medical problems with substantial genetic components, you could not get the disease. But the real thought that is expressed in the “there but for the grace of God go I” is not a metaphysical thought about what might have happened to you, but a *moral* thought: the thought that someone else faces circumstances vastly worse than yours, and that there is some basic *unfairness* in the difference, particularly an unfairness when you are in a common society with them, all equal members and all subject to the same laws. One way to capture the thought is with Dworkin’s distinction between choice and circumstance: that their circumstances are vastly worse than yours, and that the failure to remedy this inequality in circumstance shows that you are not accepting that the success of their lives matters as much as the success of your own.

3. Prudent Insurance Ideal. The problem is how, if at all, we can combine the concern with individual responsibility and equality in an account of the allocation

of resources to health care. To achieve this combination, Dworkin offers what he calls the *Prudent Insurance Ideal*. And it builds on the hypothetical insurance model that he uses in developing his theory of equality of resources.

The intuitive idea is straightforward. Suppose we return to the two problems I began with: the right amount to spend collectively on health care and the right way to distribute those expenditures. And suppose we think that the right way is that way that would result from responsible individual choices, assuming three conditions: 1) individuals have good information about risks and about technology; 2) there is a fair distribution of resources, say a distribution that meets his requirement of equality of resources; and 3) that the purchase of insurance proceeds under conditions in which people do not know their susceptibility to disease. What lies behind this third condition is the thought that susceptibility to disease is part of your circumstances. So if we begin from the thought that each person's life matters equally, and that this implies that we each ought to face equal circumstances, then we are led to the idea that when you insure against health risks, neither you nor anyone else should know the likelihoods of contracting an illness or suffering an accident. The idea is not that, as a matter of genetics or metaphysics, you literally have an equal chance of suffering a medical misfortune, but that as a moral matter your life matters equally and that you ought to face equal circumstances in pursuing your aspirations.

So we are trying to determine what we owe to each other by way of health care—what justice requires of us in this area—and we answer that question by

asking what level of insurance individuals would buy for themselves, if they were making informed individual decisions under fair conditions, where the fairness is expressed both in the assumption that the distribution of resources is just and in the assumption that the choice is made under ignorance. Dworkin offers some judgments about what results would issue from this Prudent Insurance Ideal: that is, about the insurance choices that individuals would make in this hypothetical market. So for example, he supposes that people at age 25 would not—faced with the relative costs and life benefits—buy insurance that would sustain their lives by a few months were they to fall into a persistent vegetative state. Nor would they insure to sustain their lives in late stages of Alzheimer's, or to sustain their lives for a few months when they are elderly and face a terminal illness, though they would presumably buy a policy that “keep them as comfortable and free of pain as possible.” In each of these cases, they would resist buying the insurance because they would want to invest in making their whole life as good as it could be, and would need to face directly the fact that there are costs to achieving that aspiration if they buy an expensive health insurance policy.

The idea of the Prudent Insurance Ideal is not that we should set up such a market: setting it up makes no sense, given the assumptions about ignorance that are ingredient in it. Instead he is asking the different question: if we are to establish a mandatory scheme, financed through taxes, or even an Emanuel-Fuchs type voucher system, in which we are looking to set conditions on acceptable plans and on the size of the vouchers, then what should that plan look like? We need to decide what kinds of care we owe to each other as a

matter of justice, and the Prudent Insurance Ideal is a way to answer that question. So we answer the question of what we owe to each other by asking: how would people, as a general matter, make prudent and informed choices for themselves, if they were making those choices under fair conditions? Those hypothetical conditions express the values of equal importance and special responsibility: they give us the endowment insensitivity and choice sensitivity that justice demands.

4. Reflections on the Prudent Insurance Ideal. Three observations about this hypothetical insurance method.

First, to appreciate the force of the method, suppose we think that we have a pretty good idea that people generally would buy some form of insurance—say, to cover hospitalization—but that lots of people do not actually have that insurance. Then it is natural to conclude that the reason they lack the insurance—or at least some of them lack the insurance—is that they face unfair conditions, either in having low income or in having a preexisting condition that makes the insurance more expensive than it would be under fair conditions. And if that is why they lack the insurance, then we have a good case that it is owed as a matter of justice and ought to be provided. Providing it is not a matter of paternalism: of shielding people from the unhappy consequences of their own misjudgments. Instead, the Prudent Insurance Ideal builds an idea of individual responsibility into the basic design of the system by asking what people would choose. And it also accepts—in the spirit of a division of labor—that individuals

are responsible for how they conduct their lives given the fair conditions defined by the hypothetical insurance scheme. The scheme is, as Dworkin says, egalitarian, but it is not paternalistic.

Second, there are bound to be large disagreements among us on the question of what level and kinds of insurance people will purchase under the assumption that they have a fair share of resources, good information, and no knowledge of their own susceptibilities. But the point of the ideal is not to give crisp and simple answers. Rather, it is to focus our question: so when we debate what kinds of health care we owe to one another in virtue of the special importance of health care, we ought to think of ourselves as arguing about what kinds of care would be chosen under those hypothetical conditions. The Prudent Insurance Ideal gives us a way to think about the question we are trying to answer. So Dworkin suggests, for example, that we need sometimes to bring together representatives of different groups to decide how to allocate health resources, and that those representatives will have different views on the right standards for rationing the resources (say, for end-state renal disease), but that what they are disagreeing about is what choices would be made in the hypothetical market.

Third, Dworkin supposes that we have a pretty good idea of what most prudent people would buy under the hypothetical conditions described by the Prudent Insurance Ideal, at least a good enough idea to be able to make certain kind of confident judgments. I mentioned several of those judgments earlier. But the extent of agreement in these prudent judgments is not at all clear, and

agreement may give out well in advance of the more detailed judgments that are needed in the design of the system. There are two ways to deal with this indeterminacy. One is to move to some kind of averaging of insurance decisions, which entitles individuals to the insurance that people would on average purchase under hypothetical conditions; the other is to ask what people under fair conditions would judge to be a reasonable amount to spend. Both of these changes would take us away from the idea that people are owed the insurance that they would individually have purchased for themselves under fair conditions. But they might represent acceptable ways to show that the existing levels and kinds of insurance are a product of unfairness and that remedying the unfairness is not a matter of paternalism.