Efficiency, Autonomy, and Communal Values in Health Care

Madison Powers

I. INTRODUCTION: MARKETS AND HEALTH CARE

Political debate over health-care financing in the United States has reached a new level of public discussion in recent years. Although there are many significant differences among the plans and proposals advanced by politicians, advocacy groups, health policy analysts, and economists, there also are important points of agreement among the partisans to the debate. For instance, virtually every major proposal assumes that universal access to health care is a value that public policy must promote, and opinion polls verify that this sentiment is widespread. The fundamental point of contention, then, is the means to that end. In particular, it is the role of the market in allocating health-care services that distinguishes two principal alternatives.

A. The Principal Alternatives

The first alternative seeks to restructure the present health-care system primarily by reforming the market for health insurance. Among the most widely discussed market reform plans are the following: (i) the HealthAmerica plan sponsored by members of the Senate Democratic Leadership; (ii) A Consumer-Choice Plan for the 1990s proposed by Enthoven and Kronick; (iii) the report of the National Leadership Coalition for Health Care Reform, entitled For the Health of A Nation: A Shared Responsibility; (iv) the Health Access America plan proposed by the American Medical Association; and (vi) President Bush’s recent proposals for health

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5. AMERICAN MEDICAL ASS'N, HEALTH ACCESS AMERICA: THE AMA PROPOSAL TO IMPROVE ACCESS TO AFFORDABLE, QUALITY HEALTH CARE (1990).
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insurance vouchers elaborated in "The President's Comprehensive Health Reform Program." The market reform approach has four essential elements. First, all of the major market reform proposals rely upon a decentralized or pluralist approach to health-care financing. The resulting system would comprise a variety of private health insurance programs, supplemented by federal and state-assisted public programs. All of the proposals continue to rely upon employer-based insurance for workers and their dependents as the primary means of securing health-care access, and the public programs would be designed to fill the gaps for those who are not covered through private insurance or group health insurance plans offered by an employer.

Second, all market-based proposals include general recommendations for mandating some package of minimum health benefits that must be included in any policy of insurance.

Third, most proposals contain a variety of strategies for eliminating certain barriers to insurability, providing assistance to those who lack the financial resources to obtain insurance, and either mandating or creating economic and tax incentives for employer-based health insurance coverage.

Finally, all of the proposals rely upon a variety of other measures to improve the prospects for expanded access by reducing unnecessary health-care expenditures. Suggestions range from revisions in medical malpractice law (AMA) to public initiatives to assess new medical technologies and disseminate the results of their findings to health-care consumers (NLC). All proposals recognize the need to control costs, but the Enthoven plan in particular emphasizes the role an expanded market driven by greater consumer choice might play in meeting this objective. The Health America plan would establish uniform claims and billing forms to reduce unnecessary administrative costs, and would create incentives for employers to replace open-ended reimbursement plans with managed care programs.

The principal alternative to the market reform approach is a universal entitlement program, which virtually eliminates the two most significant features of the present market for health-care services. First, it eliminates the preeminent role of private insurance companies and employer-sponsored insurance schemes as the vehicle which individuals depend upon to pay for health-care expenses. Second, it eliminates the role of the employer as an intermediary in the purchase of health insurance.

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7. PRESIDENT'S COMPREHENSIVE HEALTH REFORM PROGRAM (Feb. 6, 1992).
The best known and most representative proposal for a universal entitlement system is the Physician's National Health Plan (PNHP). Modeled on the Canadian system, PNHP proposes to cover every citizen regardless of age, medical condition, health status or employment status. Each citizen would receive a national health card, pay no medical bills for services, choose her own health-care providers, and be eligible to receive standard medical services including mental health services, long-term, and chronic care services. The resulting system guarantees universal access through a unitary financing system to be funded by the federal government and administered by the states. Levels of benefits and rates for reimbursement to health-care providers are determined universally through the political process rather than through individual contractual relations with insurance companies or employee negotiation with employers who offer insurance to their workers.

B. The Debate Over the Role of Markets

Despite what seems to be growing widespread support for reliance on the market as a social institution, many players in public policy debates have adopted a middle-ground approach that selectively eliminates or reduces reliance upon the market with respect to some commodities. Typically, commodities implicating social welfare objectives are distributed through collective decision-making rather than through the market. The result is that some allocation decisions remain primarily a matter of individual choice in the market, while others are made collectively within the political arena by democratic procedures.

Even if the current popular preference for markets has some powerful prima facie arguments in its favor, two enduring questions remain about the moral basis of the market as a social institution for making allocational decisions. First, can the choice between the market and non-market institutions be justified by an appeal to one or more primary values that ought to be promoted? For example, many economists and public policy analysts trained in economic theory defend the market as the institutional arrangement best suited to the promotion of maximal utility or economic efficiency. By contrast, libertarian political theorists often defend markets solely on the grounds that they maximally promote respect for autonomy or freedom of choice. In each of these approaches, the force of the argument depends upon the persuasiveness of the case made for the primary importance of one social goal in relation to the others we might reasonably want to achieve.

10. As the argument in the text below demonstrates, the two need not be viewed as equivalent.
Second, do the nature of the particular goods or services and the con-
sequences of treating them as market commodities affect whether they are left
primarily to allocation by individual decision in the market or to the collective
decisions of democratic bodies? Arguments for or against treating particular
goods as market commodities vary depending upon the issue at hand: sexual
services, non-therapeutic drugs, adoption, surrogate motherhood, environmen-
tal pollution permits, human organs, blood products and body parts, etc.12
Accordingly, the assessment of allocational approaches to health-care goods
may depend upon a variety of considerations, including the social or communal
values at stake.

In the sections below, I examine arguments both for and against market
allocation of health care. Arguments based upon economic efficiency criteria
are discussed in Section II. I first consider some of the inherently evaluative
elements comprising the concept of efficiency, and second, the extent to which
a market approach for allocating health care approximates the efficiency
hypothesized for an ideal market. Arguments based upon the importance of
individual autonomy or freedom of choice are discussed in Section III. I
consider the standard assumptions made about the role and moral significance
of individual choice in markets, the ingredients of market reform proposals
for health insurance, and the moral importance of individual choice in voucher
proposals and universal entitlement plans. Finally, in Section IV, I suggest
another approach for assessing public policy alternatives that focuses upon the
promotion of communal values.

I conclude that no single criterion for assessing competing public policy
alternatives for health-care allocation will provide sufficient grounds for
decision-making, and that many of the most important value considerations
relevant to that choice are likely to be ones other than efficiency or autonomy
alone.

II. EFFICIENCY: THE FOUNDATION OF WELFARE ECONOMICS

Efficiency in the design and function of social institutions is an intuitively
appealing goal. In the ordinary sense of the term, we usually think of an
institution as efficient to the extent that it avoids waste, or produces the
greatest benefit, with the least expenditure of limited resources. Moreover, its
intuitive appeal is enhanced by its seeming lack of dependence upon controver-
sial value assumptions. It would seem difficult to deny that whatever else we

12. See, e.g., Elizabeth S. Anderson, Is Woman's Labor a Commodity?, 19 PHIL. & PUB. AFF. 71;
TITMUSS, THE GIFT RELATIONSHIP (1971); Margaret J. Radin, Market-Inalienability, 100 HARV. L. REV.
want in an institutional arrangement we want it to be efficient. However, the concept of efficiency is more complicated for two reasons.

First, public policy analysts, influenced by theoretical developments in a branch of economic theory known as welfare economics, understand this intuitive notion of efficiency in a highly technical sense. In particular, they focus on several conceptions of Pareto optimality and productive efficiency to evaluate public policy options. This section considers the adequacy of these popular efficiency criteria from the perspectives of both utilitarian moral theorists and those who emphasize concerns about distributive justice.

Second, proponents of market allocation claim that efficiency arguments provide a value-free basis for comparing policy options. For example, E.J. Mishan claims that Pareto optimality is for most economists the kind of ethical proposition that would "appear to be too obvious to warrant mention" and that, accordingly, forms part of the "virtual constitution" for decision-making in democratic society. Richard Posner, who offers his own account of efficiency, argues that the sole standard for evaluating governmental policy decisions is one that is in everyone's antecedent interest to accept and can be deemed a principle which would be agreed to in advance. Others argue that efficiency is a value-neutral approach to comparing policy options because it is compatible with other important values. For example, some argue that efficient markets provide the most equitable or fairest means of allocating scarce resources since they neither impose schemes of resource redistribution upon society nor interfere with the rights of citizens to acquire and dispose of their property. A related claim suggests that the market best promotes economic efficiency and simultaneously maximizes individual freedom of choice. In this section, I reject the claim that the various formulations of efficiency criteria are value-neutral, and I argue instead that any notion of efficiency is inherently evaluative. Although it is widely assumed that the definition of efficiency itself is sufficiently precise as to be uncontroversial, the term can actually be defined any number of ways, each of which harbors important but often neglected normative assumptions. Consequently, purely economic efficiency arguments provide persuasive reasons neither for favoring one social

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15. Mishan, supra note 13, at 162.
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policy over its alternative, nor for favoring market over non-market alternatives.

A. Definitions of Efficiency

1. Efficiency as Pareto optimality

Scholars of welfare economics most often equate efficiency with the criterion of Pareto optimality. Pere optimality denotes the equilibrium state reached when no one can be made better off without someone being made worse off. An allocation of resources is said to be "Pareto superior" to its alternative if a further reallocation can improve the well-being of at least one person without making someone else worse off. Thus, a Pareto optimal system is one in which there are no Pareto superior states.

The enduring appeal of the Pareto criterion has stemmed mainly from its connection to the concept of market equilibrium under perfect competition. There is, however, no necessary connection between the achievement of Pareto optimal states and the existence of competitive markets. Nonetheless, as A.K. Sen has observed, the closeness of this connection understandably has led economists to hypothesize that the Pareto optimum state must be achievable through market competition. Accordingly, most economists have been strong supporters of the market as the most effective way to achieve Pareto optimality.

The most familiar interpretations of—and justifications for—the Pareto criterion are rooted in classical utilitarianism. According to the classical utilitarian interpretation, only Pareto optimality identifies the system that yields the greatest total utility or aggregate overall well-being.

Yet the connection between utilitarianism and Pareto criteria requires a more careful examination. A system that allows someone to be made better

20. For a useful introduction to Pareto optimality and the various interpretations that have been presented, see MISHAN, supra note 13, at 159; AMARTYA K. SEN, ON ETHICS AND ECONOMICS 31-40 (1987); JULES COLEMAN, MARKETS, MORALS AND THE LAW 95-130 (1988); ALLEN BUCHANAN, ETHICS, EFFICIENCY, AND THE MARKET 1-46 (1985).

21. This connection is spelled out in what is known as the Fundamental Theorem of Welfare Economics. As Arrow and others have demonstrated, under certain conditions every perfectly competitive equilibrium is Pareto optimal (the direct theorem), and under some additional conditions, every Pareto optimal state is also a perfectly competitive equilibrium (the converse theorem). Although both parts of the theorem have been established under certain restrictive assumptions, the assumptions are not the same in both cases. See, e.g., Kenneth J. Arrow, An Extension of the Basic Theorems of Classical Welfare Economics, in PROCEEDINGS OF THE SECOND BERKELEY SYMPOSIUM ON MATHEMATICAL STATISTICS AND PROBABILITY 507 (Jerzy Neyman ed., 1951); S. Winter, A Simple Remark on the Second Optimality Theorem of Welfare Economics, 1 J. ECON. THEORY 99 (1969); G.C. Archibald & David Donaldson, Non-Paternalism and the Basic Theorems of Welfare Economics, 9 CAN. J. ECON. 492 (1976).

off without someone being made worse off is comprised only of gainers, no losers. Since overall utility increases, the system is also Pareto superior to its alternative. Even if every Pareto superior policy move increases overall utility, however, a particular Pareto optimal system is not necessarily the one which results in maximal overall utility. Maximal utility might in principle result if some were permitted to lose so long as the gains of the winners outweighed the losses of the losers.\(^{23}\) Pareto optimality nonetheless requires that there be no losers. Thus there is no necessary connection between Pareto optimality and utility maximization, but only the expectation that movement toward Pareto superior states represents increases in overall utility.

A utilitarian might endorse the Pareto criterion on the hypothesis that maximal production of total utility within society will most likely result from the promotion of Pareto optimal policies. But we would need some direct way of measuring the utility of each in order to know if Pareto optimal policies actually maximized total utility. Moreover, because the traditional utilitarian account of total utility is obtained by summing or aggregating individual utilities, we must be capable of making interpersonal utility comparisons in order to know how the Paretian notions of “better off” and “worse off” are to be understood and to know whether Pareto optimal policies actually are utility maximizing. Some utility theorists have argued that interpersonal comparisons of utility are impossible on the grounds that we do not have access to reliable information about the utilities of each individual.\(^{24}\) Although others have argued that this concern is unfounded, proponents of alternative conceptions of the Pareto criterion claim that their interpretations eliminate whatever problems traditional utility theory faces in this respect.\(^{25}\)

One such alternative utilizes what we might call a “revealed preference” theory account of the crucial terms “better off” and “worse off,” which avoids having to measure utility directly. According to the Axiom of Revealed Preference, an individual’s choice in the market reveals the individual’s preference.\(^{26}\) The assumption is that ordinary market behavior accurately portrays what people actually prefer and that people do not make choices against their own calculations of individual utility.

Much of the attraction of the revealed preference approach lies in its theoretical simplicity. It makes the plausible assumption that individuals are

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23. There are, however, some problems with the utilitarian defense of the Pareto criterion. Pareto improvements increase total utility but not all increases in total utility result in Pareto improvements. See COLEMAN, supra note 20, at 100-102; L. Bebchuk, The Pursuit of a Bigger Pie: Can Everyone Expect a Bigger Slice?, 8 HOFSTRA L. REV. 671, 691-4 (1980).


25. Allen Buchanan, for example, suggests that this view rests upon a discredited philosophy of mind. BUCHANAN, supra note 20, at 7-8.

formally rational in the sense that they do not ordinarily make choices that conflict with their utility functions. Because it is necessary under this approach to determine only whether each individual is better or worse off relative to his or her own former condition, it avoids the problems posed by interpersonal comparisons of utility. On this view, a system in which no one can be made better off without making someone worse off is simply one in which there are neither potential sellers willing to sell nor potential buyers willing to buy.

In addition, the revealed preference theory has a normative or ethical attraction for many theorists. It does not require the theorist to make controversial value assumptions about what constitutes a true gain in individual well-being. Theorists simply look to market behavior to determine preferences, operating under the assumption that individual preferences are dispositive of the issue of whether individuals are better off or worse off. In short, this interpretation holds out the promise of providing a value-neutral way of approximating individual utility, and hence of total utility, without presupposing either any direct way of measuring utility or any controversial assumptions about what individuals ought to prefer.

Other proponents of the revealed preference approach to the Pareto criterion justify it for reasons unrelated to hypotheses about utility maximization. For them, the Pareto criterion appears to have additional normative appeal as an account of equity in distribution. Some argue that pursuit of Pareto optimal states is justified "not because applying it gives an index of total utility, but because rational self-interested persons would consent to its use." How could it not be rational to prefer a system in which no one loses and some may gain? As long as some may continue to gain, while no one loses—or at least so long as the losers are adequately compensated by the gainers—everyone has reason to prefer the Pareto optimal system.

Furthermore, because these theorists consider efficiency to be an adequate account of equity or distributive justice, it represents a comprehensive criterion for comparing alternative public policy options. And, of course, their standard argument is that the institutional arrangement best designed to achieve Pareto efficiency and the additional objectives it comprehends is the market.

Objections to the revealed preference interpretation of the Pareto optimality criterion fall into two categories. The first type admonishes the revealed preference approach for not adequately measuring true or actual utility. This attack turns on two assumptions: that choice reveals preference; and that

27. COLEMAN, supra note 20, at 101.
28. Duncan K. Foley, Resource Allocation and the Public Sector, 7 YALE ECON. ESSAYS 45 (1975); Hal R. Varian, Equity, Envy and Efficiency, 9 J. ECON. THEORY 63 (1974) (arguing that an equity-efficiency trade-off will exist only if there is no feasible allocation that is simultaneously Pareto efficient and equitable in the sense that no one envies another's position).
29. For a discussion of these widely familiar claims made for the efficiency of markets, see SEN, supra note 20.
preference is a reliable guide to utility. The second kind of objection focuses on considerations of fairness or distributive justice.

a. Revealed Preference and Utility. In a narrow sense, it is plausible to assume that choice in the marketplace reveals preference. As among the alternatives open to consumers, it is reasonable to assume that minimally rational persons do express their preferences through the choices they make. It would be highly counterintuitive to assume the contrary. Nevertheless, markets for certain goods may unduly restrict the available alternatives from which consumers may choose. If one's choices are narrowly constrained by the configuration of the market, then market behavior may not be an accurate reflection of an individual's true preferences. The problem (which I will discuss in greater detail in Section III) can be illustrated by the constraints individuals face in purchasing personal health insurance policies.

Most health insurance policies are made available through employment, and most individuals lack the ability to purchase similar coverage on their own at comparable prices. The primary reason that employers can purchase group insurance for their employees on more favorable terms is that they offer insurance companies a larger pool of insureds over which the risk of having to pay benefits may be spread. With enough employees in the insurance pool, the insurer can expect a predictable average rather than the uncertain risk that would attach to individuals with differing medical conditions. Given the ability of insurers to control risks in this manner, employers can obtain more favorable premium rates and employees can obtain coverage without individual medical examinations. Individuals, however, are subject to medical underwriting requirements designed to eliminate those who, by virtue of medical condition, may be more costly. The rationale for assuming that individuals are riskier to insure—and therefore warrant medical examination—is based, in part, upon the assumption that the category of persons not covered in employment-based plans are more likely to contain disproportionate numbers of older persons, physically disabled persons, and persons who, because of their knowledge of severe preexisting medical problems, are likely to seek higher levels of insurance coverage to defray large anticipated expenditures for medical services. As a consequence of these differential underwriting requirements, the available choices of many consumers may be severely limited in a market for health insurance.

Whether or not choice is an adequate indicator of preference, it is always an open question whether preference is an adequate measure of well-being. In situations in which the information required for informed preferences is too

difficult to obtain or too complex to appraise, preference may not be a reliable measure of well-being. This point can be illustrated by problems consumers will likely face under President Bush's proposal for increasing access to individual insurance by offering tax credits for the purchase of individual insurance. Individuals who obtain private insurance under this plan would face a number of obstacles in choosing among the variety of plans offered in the market.

First, consumers often lack considerable information relevant to an informed decision. As anyone who has ever pondered over a medical bill to determine what portion of the bill for medical services is paid for by the insurance company knows, most consumers have incomplete information about what benefits they will receive should they need medical care. They may know, for example, that certain services are covered, that certain services will be reimbursed up to a fixed dollar amount, or that some things explicitly are not covered. Yet they generally do not know what they themselves may have to pay in many instances. Although insurance policies may set ceilings on annual out-of-pocket payments, individuals do not and cannot know how much of a specific medical bill they will have to pay. This is because insurance policies typically promise to pay a proportion (e.g., 80%) of the “usual and customary” charges for a given service. Often the basis for calculation of usual and customary charges is information that the insurer compiles but does not make available to the policyholder in advance.

Second, consumers may lack the knowledge or specialized understanding necessary to assess the information provided in a particular insurance plan. They may not know whether certain therapies are the ones which ordinarily are reimbursed by the insurer, or those which the insurer will deem unproven or experimental and for which no reimbursement will be paid. An individual lacking sophisticated knowledge about cancer therapies, for example, may be unable to appraise what she is buying when she purchases an insurance policy.

Third, a consumer's choice may not reflect his true interests because of a lack of prudence or imagination about future needs. Consumers who believe themselves to be in good health may choose policies that do not adequately cover future medical contingencies, either because they think they will never need certain coverage or because they are insufficiently aware of the kinds of medical risks they face. This kind of problem would be exacerbated greatly if we were to implement new proposals allowing insurance companies to offer competitive policies with considerably fewer benefits at lower prices.

The utilitarian proponent of market efficiency might respond by claiming that although the potential exists for actual individual well-being—and hence

33. JAMES GRIFFIN, WELL-BEING: ITS MEANING, MEASUREMENT, AND MORAL IMPORTANCE (1986) (surveying the problems of various mental state accounts, desire accounts, and preference-satisfaction accounts of utility).
total utility—to decrease under a market-based health insurance system, greater overall utility will most likely result if individuals are free to make their own choices in the market for medical care, as with any other marketable item. Put another way, utilitarians assume that since individuals are likely to be better judges of what is important to them, freedom to make their own choices should maximize utility. Although this hypothesis may have some plausibility when the goods in question are automobiles, televisions, and airline tickets, the case seems much weaker in the context of a market for health insurance, where individuals may be incapable of determining their own best interests in the market.34

b. Equity Objections. Pareto optimality as an ideal to be achieved through the market raises additional worries about distributive consequences. Although Pareto optimality and Pareto superiority are conceptually linked—there are no states that are Pareto superior to a Pareto optimal state—Jules Coleman has shown that a Pareto optimal position can be reached by a succession of steps that are either Pareto superior, Pareto inferior, or a combination of the two. To say that the Pareto optimal state is the preferred ultimate outcome does not commit one to the normative proposition that the only morally justified way to reach Pareto optimality is through Pareto superior policies—i.e., ones that condition someone being made better off on no one being made worse off.35

This distinction has importance for one’s view of the moral justification for the market. Even if one favors the market due to its tendency to promote Pareto optimal states in the long run, there is no guarantee that successive positions along the way will be increasingly Pareto superior. Indeed, if preference may be an unreliable indicator of true utility, then there is every reason to suspect that along the way the market approach will produce gain for some to the detriment of others—in terms of real utility—as the result of personal choices expressed through the market mechanism. Pareto optimality thus remains an elusive regulative ideal, which the fate of participants in actual markets may never approximate.

Because of the large gap between Pareto optimality in its ideal and realized forms, it may be reasonable at some point to reject the Pareto standard as an adequate criterion of equity.36 To bring this point into the context of health

34. I consider this point in greater detail infra part III.
35. COLEMAN, supra note 20, at 72.
36. Whether it is irrational to object to the possibility of others being made better off as long as no one is made worse off depends to a large extent upon the patterns of distribution that characterize the move from an initial state to a Pareto superior one. For instance, if the initial patterns of distribution are such that the utilities of those who neither gain nor lose are considerably less than the initial utilities of potential gainer, then each successive move to Pareto superiority may increase the differential between the utilities of the best-off and worst-off members of society. For some criticisms of Pareto optimality as a criterion of equity, see Sen, supra note 22, at 1; Lawrence G. Sager, Pareto Superiority, Consent, and Justice, 8 HOFSTRA L. REV. 913 (1980). There are various counterarguments to ethical objections of this sort made
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care in the United States: a Pareto superior health-care system might allow the currently insured (and typically high-wage) citizens access to a rich package of services, while providing low-wage workers and their dependents (many of whom currently are either uninsured or underinsured) with a minimum level of care. Some critics of market-based health insurance proposals will argue that a preferable public policy would make the worst-off much better off even at the expense of the best-off members of society. As we shall see, those critics also will tend to favor Canadian-style, single-payer reform plans.

Equity objections to market-oriented medical insurance reform plans become particularly powerful when directed at the revealed preference approach underlying such proposals. Throughout this article, I suggest that reliance upon the expressed preferences of individuals as a way of interpreting whether they are better or worse off may fail to reflect their actual utilities. Moreover, since the revealed preference approach relies on a subjective understanding of whether an individual is better off or worse off relative to his own former condition, and since individuals may underestimate their true utilities, this approach permits even greater disparities among the best-off and the worst-off in society.

2. Productive Pareto Efficiency

Supporters of markets often hypothesize that markets will achieve what has been called productive Pareto efficiency. The productive efficiency criterion can be viewed as a simplifying assumption: State A\(^1\) is said to be superior in terms of productive Pareto efficiency to State A\(^2\) if it is possible in A\(^1\) to

against Pareto optimal markets. See, e.g., NOZICK, supra note 17 (arguing that inequalities of outcome in markets are not morally objectionable if individuals have rights to property and there are no injustices in acquisition or transfer); P.T. BAUER, EQUALITY, THE THIRD WORLD AND ECONOMIC DELUSION (1981) (arguing that inequalities are largely a product of differences in the capacities and motivations among persons, and persons have a right to what they produce); Varian, supra note 14 (arguing that some but not all Pareto-efficient states achieved through market exchange will be equitable).

37. Norman Daniels, Is The Oregon Rationing Plan Fair?, 265 JAMA 2232 (1991). To make matters worse, most proponents of the Pareto criterion endorse a much weaker version of the criterion than the simple versions presented so far. Instead of assuming that a Pareto superior state of affairs must be one in which someone can be made better off and no one will be made worse off, the criterion is relaxed to require only that it is possible for the winners to compensate the losers, and not that they actually must do so to prevent some from being made worse off by a change. The potential Pareto improvement criterion, or Hicks-Kaldor interpretation as it is widely known, has considerably less attraction in as much as it is consistent with a great many people actually being made worse off. See MISHAN, supra note 13, at 173-79.

38. It is important to note, however, that these equity objections also apply to possible formulations of Pareto optimality that do not rely upon the revealed preference approach. For instance, the Pareto criterion might be reformulated in terms of objective or actual utilities. Pareto optimal states would be ones in which no one can be made objectively better off without someone else being made objectively worse off. The equity objection still applies in as much as some would be made vastly (objectively) better off while others would simply be made no worse off (objectively) relative to their own former condition.
produce more of at least one good without producing less of some good produced in $A^2$.\textsuperscript{39}

The appeal of the Pareto productive efficiency criterion lies in its assumption that ordinarily it is rational to prefer a system in which more goods are produced. Thus, as long as at least more of one good can be produced without producing less of another good (an outcome presumed possible in genuinely competitive markets), an increase in the total production of goods will reflect greater aggregate utility. As with the traditional Pareto criterion, there would appear to be only winners and no losers. If this underlying assumption holds true, then the productive Pareto efficiency criterion would serve as a rough proxy for the traditional Pareto criterion.

It is important to see how such a hypothesis might be defended. Arguments for markets on the grounds of productive Pareto efficiency suppose that patterns of production and consumption—driven by the pursuit of self-interest and coordinated through the workings of the price mechanism—make market exchange mutually beneficial to individuals and advantageous to society overall. Hence the anticipated beneficial consequences of market competition: (a) aggregate and individual cost-containment (making more goods of a particular type available lower costs); and (b) rational resource allocation in the production of competing goods. Put another way, if individual consumer choices are made more sensitive to costs in a competitive market, then consumers will make more rational decisions about the particular goods for which they are willing to pay. Consequently, each individual will be made better off—or at least no worse off—in two respects: first, cost control will free up valuable social resources, and thereby improve individual well-being by providing a better mix of particular goods, such as health care, relative to other goods they need. Second, individuals will get more of what they want overall, given the limited resources each has to spend for competing goods.

But is this account of efficiency adequate as a basis for evaluating alternative public policy options, including medical-care reform plans? For a variety of reasons, policymakers ought to be skeptical of the productive Pareto efficiency concept. First, as explained above, productive Pareto efficiency in some cases may insufficiently measure the comparative well-being of United States citizens under each alternative proposal. Secondly, if the additional goods produced under a market-based public policy do not actually improve anyone’s well-being, as skeptics may claim, then enhanced competition is bound to promote the production of additional goods that are either of no genuine value or some disvalue to society. Thirdly, unrestricted markets also could encourage consumers to make irrational choices. For example, consumers may prefer goods that allegedly cause comparatively little or negative

\textsuperscript{39} Buchanan, supra note 20, at 18.
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increase in well-being—electronic gadgets and novelty items, cigarettes and alcohol—to education, prenatal care and other goods that ostensibly result in greater utility. Accordingly, as market opponents frequently argue, certain goods are so vital that the government is justified in intervening in the market to change the demand for and distribution of them. These critics may argue for the imposition of taxes in order to discourage consumption of tobacco and alcohol or for more expenditures on social resources to provide free school lunches, textbooks, or childhood immunizations. In each instance the critics' claim remains constant: increased availability of goods alone is not—nor ought to be—the sole criterion of public policy assessment.

Two examples from the health-care context will illustrate this point. First, some health-care goods available in the marketplace may be of little or no therapeutic value. Critics complain that many virtually worthless—and perhaps even harmful—medical technologies, therapies, and pharmaceuticals remain in the marketplace for an extended time even though they have never been proven effective. In such cases, producers in competition with one another may have incentives to reduce the costs of production, and consumers may have more available goods as a consequence. But no real gain (perhaps even a substantial loss) in utility emerges because the introduction of such medical goods does not improve (and may even worsen) health outcomes.

The second example involves the contrast between life-extending treatments and life-improving treatments. Some technologies may greatly improve life without significantly extending life. Examples include joint replacement and magnetic resonance imaging (which reduces the pain of myelography and arthroscopy). As Charles Normand contends, little evidence suggests that either extend life.40 By contrast, other therapies arguably extend life for a limited time without improving life. If the operation of the market results in more goods of the latter sort, then it is at least plausible to argue that the market has not increased utility. It is important to note that this market criticism does not depend upon the assumption that there will be fewer life-improving technologies available due to higher social outlays for life-extending technologies. One may plausibly claim that the introduction of such technologies brings either worthless or harmful results, even if it does not directly decrease the availability of life-improving technologies.

The force of such objections depends upon the reasonableness of the underlying judgments about which medical goods genuinely enhance well-being. Whether more goods such as cigarettes, alcohol, nuclear weapons, or medical technologies add to or reduce utility depends, in turn, upon controversial value assumptions. Yet this is precisely the point the critic of the

productive Pareto efficiency criterion wishes to underscore: we cannot determine whether one social arrangement is better than another without engaging in inherently controversial, evaluative debates over what constitutes well-being. The mere fact of increased production does not establish its superiority. Accordingly, even productive Pareto efficient markets reasonably may be rejected, if one can make the case that achieving such efficiency does not enhance well-being.

Another objection to the productive Pareto criterion focuses upon the presumed role of producer incentives in achieving productivity. The contested claim is this: when producers have greater incentives to produce more goods without additional expenditure of social resources, consumers benefit by having more goods available at lower costs, and society benefits by having more resources left over for the purchase of other goods.

The market for health insurance may nonetheless provide a counterexample to the general hypothesis that the structure of market incentives tends toward the availability of more goods. Even if more goods produced by manufacturing firms become available as a consequence of firms' economic incentives to find cheaper ways to produce those goods, overall utility may decrease. How can this be so? As long as access to health insurance primarily is tied to employment, employers have strong incentives to increase firms' productivity by eliminating employees who will increase their health insurance premiums. And as long as the costs of production can be constrained by selective hiring practices, this incentive will remain significant among employers who choose to self-insure, even if discrimination for insurance eligibility is made illegal. The consequence: fewer individuals may be able to obtain adequate health insurance at affordable costs. Put simply, industry's incentive to make the goods it produces available at lower costs may result in fewer goods of another sort—namely health care—being made available to American workers.

Once critics of market reform proposals for the medical-insurance market demonstrate that problems—i.e., skewed consumption patterns and lost utility due to selective hiring practices—will inhere even in productive-Pareto-efficient health-care markets, they then frequently recommend a variety of remedial interventions. One relatively modest intervention would be to make product availability subject to more rigorous initial technology assessment. Certain products would not be allowed to enter the market until substantial scientific evidence of their effectiveness exists. The market for services would remain otherwise unaffected and the role of private insurers might continue, but insurers would be permitted to pay only for services given prior regulatory approval. A more ambitious intervention would be to eliminate private insurers altogether and replace them with a single-payer system in which the govern-

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...ment makes and implements decisions about what goods and services will be available. The choice between these alternative market interventions would turn most importantly on considerations about the comparative administrative costs attached to each strategy.

3. Efficiency as Wealth Maximization (the productivity criterion)

Closely related to the productive Pareto efficiency criterion is the concept of productivity. Productivity denotes maximizing economic outputs relative to resource inputs. One system is superior to another in terms of productivity if more economic output can be produced in that system than in another, given the same utilization of resources. The standard measure of output on the productivity criterion is either economic growth rate or a higher rate of capital accumulation: hence the alternative way to conceive of productive efficiency, namely as wealth maximization. The wealth maximization view has conceptual affinities with the standard Pareto criterion, but it offers a non-utilitarian interpretation of Pareto superiority. Instead of claiming that one system is Pareto superior if at least one person’s utility is increased and no one’s utility is decreased, it would claim that Pareto superiority exists where at least one person is wealthier and no one is less wealthy.

The initial plausibility of the productivity criterion derives from the simple notion that it is generally preferable for a society to produce more wealth with equal resources. And as Allan Buchanan notes, its connection with the market

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42. The productive Pareto efficiency criterion does not assume, for purposes of comparison of states of affairs, that economic inputs are held constant. It is only concerned with a greater economic output of goods without reduction of output of other goods. A productive Pareto superior outcome might involve more resource utilization to increase output, but the productivity criterion is concerned with overall output relative to a given set of initial resource inputs. Of course, productivity comparisons are made easier if the increase in overall output does not involve comparisons between states of affairs in which differing amounts of one good is not a variable. The standard method of comparison involves selection of some type of output, or set of outputs produced in two systems and determining which produces the more favorable ratio of outputs to inputs.

43. For those familiar with the literature of the law and economics movement, the similarity between productivity and what is sometimes called allocative efficiency will be noted. Allocative efficiency is concerned with the maximum use of productive resources, but the emphasis is on the proper allocation of resources for maximally producing goods. Much of the discussion in the law and economics movement focuses on the assignment of property rights to productive resources. The rational allocation of such rights, according to some theorists, is designed to maximize profits through optimal use of productive resources. Although it is unclear in the literature whether productivity and allocative efficiency are identical concepts, both conceptions share the view that the basis for comparing alternative states of affairs is wealth maximization. Coleman, for example, seems to suggest their equivalence in his reference to a discussion of productive efficiency which points to sections of his own work which use the notion of allocative efficiency. COLEMAN, supra note 20, at 354 n.6. Additionally, the literature reflects a variety of other conceptual concerns, many of which are beyond the scope of this discussion. Many claim that maximizing utility is extensionally equivalent to maximizing profit or wealth (which my argument questions). There is a lively debate about whether this claim is true, and whether wealth-maximizing notions of the sort I discuss in terms of productivity ought to be viewed as efficiency criteria. For one of the best discussions of many of these issues, see COLEMAN, supra note 20, at 95-123.
lies in the assumption that market exchange will increase the size of the economic pie "by placing resources in the hands of producers who will most closely approximate the least costly methods of production."\textsuperscript{44} This prospect supplies the rationale upon which many developmental economists, including many at the World Bank, depend in defense of the productivity criterion and its emphasis upon wealth maximization as the single most important test for comparing alternative social institutions.\textsuperscript{45}

The case for endorsing markets on grounds of productive efficiency derives additional legitimacy from the following hypothesis: that the competitive incentive to produce cheaper goods will not only make available more goods of a particular type, but also will increase the supply of other goods by freeing up valuable social resources for uses that create more wealth. For instance, in the context of health care, market advocates claim that either improperly functioning markets for health services or extensive government involvement in non-market provision of health care adversely affect society’s overall wealth. Certain economists further claim that an economy that devotes too great a share of its resources to health care will likely reduce its rate of economic growth.\textsuperscript{46} According to their argument, the delivery of medical-care services consumes more than its share of resources (because of its labor intensity) to the detriment of other economic sectors such as manufacturing.

There are three major objections to using the productivity criterion as the sole basis for comparing alternative public policies in general, and in particular, with respect to health-care and medical-insurance reform plans.\textsuperscript{47}

First, it is unclear whether wealth maximization or economic growth is an adequate measure of well-being. To begin with, aggregate social wealth only roughly approximates the aggregate well-being of a society. A system of production with a high rate of wealth accumulation may make people better off, but that is not necessarily the case. If, for example, the system distributes the produced goods inefficiently among those who would most benefit, then many people may not be made better off in terms of physical (or emotional) well-being.\textsuperscript{48}

Secondly, a system that maximizes wealth by promoting economic growth may nonetheless fall short on equality grounds. Just as the goal of maximizing aggregate utility is compatible with significant inequalities in the distribution

\textsuperscript{44} BUCHANAN, supra note 20, at 18.
\textsuperscript{45} See Normand, supra note 40, at 1574.
\textsuperscript{46} See ROBERT BACON & WALTER ELTIS, BRITAIN'S ECONOMIC PROBLEM: TOO FEW PRODUCERS 13-16 (1976).
\textsuperscript{47} There are a number of motivations for adopting a wealth maximization approach, most of which are beyond the scope of this discussion. Apart from certain objections to utilitarianism as a normative moral theory, the wealth maximization approach allows the Hicks-Kaldor account of the Pareto criterion to avoid the Scitovsky paradox that undermines the utilitarian account of efficiency. For a fuller account of these and other defenses of and objections to wealth maximization, see COLEMAN, supra note 20, at 95-132.
\textsuperscript{48} BUCHANAN, supra note 20, at 6-7.
of utility, a principle of wealth maximization is similarly compatible with significant inequalities in the distribution of wealth.

If these first two objections are applied to the evaluation of health-care systems, then it is reasonable to ask whether we should not rationally prefer a less productively efficient system of health-care delivery with more distributive equality to one that maximizes the rate of wealth accumulation with less equality in its distribution. For example, a health-care delivery system may generate greater economic growth overall if more services may be delivered at less per-unit cost. But if that increased productivity results from lessening the availability of services in more geographically remote regions, then the well-being of significant populations declines considerably. It therefore seems that although the promotion of wealth maximization through productive efficiency increases the size of the economic pie (by placing resources in the hands of producers who will most closely approximate the least-costly methods of production), health care provides a clear example of how that increase may be non-beneficial to substantial portions of the population. Both utilitarians and non-utilitarians alike have reasons to complain about outcomes of this kind.

It is important to note that objections of this sort to market-oriented proposals carry the debate on health-care delivery beyond the range of concerns about the roles of private health insurers versus governmentally administered, single-payer plans. They raise concerns about whether purely fee-for-service medicine, however financed, will result in delivery of services to those who need them. Barriers to insurability and the high costs of health care (attributable in part to the present insurance system) are but two components of the limited access problem. While the problem of medically underserved urban areas directly relates to lack of resources for purchasing insurance, the lack of access in rural areas more realistically reflects the economic incentives for health-care providers to deliver services where the per-unit cost of delivering services may be less and profitability will be greater. Any proposal for health-care reform will have to address this additional problem, whatever role it assigns to the market in the allocation of insurance.

A third objection to the productivity criterion involves another kind of inefficiency that may result from social policies attaching primary importance to wealth maximization. A system is said to be “aggregatively inefficient” if it fails to employ all available productive resources. The current employment-based approach to health-care finance illustrates the potential for conflict between aggregative efficiency and productive efficiency. Because employers have substantial economic incentive to control the costs of production, they also have strong incentives to control the insurance costs attributable to their employees. As indicated earlier, one meaningful way to control such costs is to exclude from the workforce employees who potentially are expensive to insure due to their preexisting medical conditions. Such exclusionary hiring
decisions promote aggregative inefficiency—in the form of underutilized human resources—even if such practices simultaneously contribute to the economic growth of individual firms. Put another way, if large numbers of persons with skills and productive potential are effectively excluded from the workplace and denied medical insurance coverage, then producer incentives to reduce costs may lead to an undesirable social outcome. Put yet another way, if utilization of additional resources—in the form of available but unemployed labor—would increase the output of utility-producing goods, then a productively efficient, wealth-maximizing health-care system reasonably may be judged inferior to its alternative.

4. Cost Control and Efficiency

A frequent complaint lodged against the present health-care financing system in the United States is that health care eats up an inordinate share of U.S. Gross Domestic Product (GDP). It is often noted that health care accounts for approximately 13% of U.S. GDP, compared to substantially lower percentages for other industrial nations. From some theoretical perspectives, it is not obvious why this fact should be a cause for concern. According to the revealed preference interpretation of Pareto efficiency, the pattern of aggregate expenditures merely reflects sum of individual preferences. If consumers wish to spend more for health care relative to other goods, then that simply is a matter of what they prefer. Equally, from a libertarian perspective—one that defends the market on grounds of primacy of unrestricted individual choice—the fact of proportionately higher GDP devoted to health care is not per se objectionable. By contrast, the proponent of the productivity criterion is concerned with the impact of health-care costs on wealth accumulation. As we have seen, however, it remains unclear why this consideration should be a decisive concern in the area of medical care.

A more telling criticism of American medical care claims that the United States devotes too many social resources to health services of a non-beneficial type in proportion to other goods and services that may better promote well-being. In order for aggregate costs to matter, there must be other evaluative or empirical premises presupposed by the critic; here, the critic assumes that current levels of expenditure do not accurately measure true utility. That is to say, certain uses of social resources do not result in real benefit to individuals or to society overall. Put another way, expenditures on medical goods and services that reach few consumers and provide little or no real benefit have

50. ENGLEHARDT, supra note 11, at 357.
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the further effect of wasting limited social outlays, thereby depriving many of access to basic health services (e.g., prenatal care), according to this view.

In short, the most familiar objections to the current system of financing health care in the United States are largely evaluative in nature, rather than based on purely economic arguments dealing with efficiency. But where has this mixture of empirical and evaluative assumptions (that may motivate both complaints and proposed solutions to the current level of medical expenditures) gotten us in terms of the debate on health-insurance reform? A quick review of the most popular positions may help to illuminate.

Many blame the current unsatisfactory state of affairs on the presence of substantial barriers to competition in the health-care market. Their prescription: reform the present market so as to achieve a more rational use of resources. These advocates predictably adhere to the traditional market view, which assumes that a competitive market will reduce the individual cost of goods by encouraging greater price-consciousness. Chastened producers will then lower costs of production or find alternative ways to produce the goods.

Yet the traditional model of market competition may be inappropriate when it comes to evaluating the current state of our health-care finance system. The chief problem most market reformers have identified is this: since consumers rely upon insurance to pay medical bills, the usual relation between willingness to pay and cost is interrupted. Traditional insurance policies pay all or some substantial portion of the consumer's medical bills, and therefore simply pass along the increased costs through higher premiums. Under this arrangement, it is individually rational (at least in the short term) for each person to get all potentially beneficial medical services without appropriate regard to cost. There is too little incentive to economize or tailor individual medical decisions to cost considerations. Correspondingly, there is insufficient pressure either on insurers or on health-care providers to control costs. Thus, what initially appears individually rational in the current market—both for consumers and providers—becomes over the long run collectively self-defeating, in the sense that overall societal costs are not constrained; and individually self-defeating, in the sense that costs of health care and insurance continue to rise uncontrollably.

Among the most prominent market-oriented solutions stands the proposal to virtually eliminate the traditional open-ended insurance system in favor of managed care plans. Managed care plans are insurance plans priced according to the level of benefits provided so that purchase decisions are made in advance of illness and with greater regard to cost. Individual consumers must evaluate what proportion of income they are willing to devote to cover anticipated medical needs. Administrators of managed care plans, meanwhile, are

51. See, e.g., Enthoven & Kronick, supra note 3.
forced to project cautiously their anticipated expenditures in order to price each plan appropriately. Ultimately, managed care plans contain costs by limiting the choice of providers to those who agree to hold costs within specified limits and by ensuring that health-care providers do not perform unnecessary or non-beneficial services.

An alternative, non-market-based explanation of the current state of affairs is more fundamental in its critique: it holds that there is something about the nature of health care as a commodity that makes it peculiarly ill-suited to market allocation. Simply stated, the costs of medical care may be too high because consumer preferences have too much effect on costs. According to this view, consumer preference often is a poor indicator of objective utility: consumers want health services that generally are available but not clearly medically beneficial.

Contrary to the view that high costs are primarily a function of impediments to competition (which otherwise would ensure that consumer preferences hold down costs), it is the fact that consumers want what they ought not to want that forms the crux of the problem, according to opponents of market-oriented health-care reform. Hence the non-market remedy: decrease rather than increase the responsiveness of health-care providers to consumer preference (either by convincing people to modify their preferences, or by relieving them—and the market—of certain medical decisions) and rely instead upon collective, democratically formed judgments. This remedy assumes that decisions about the services to be provided and the rates of reimbursement to be paid to providers should be made only after decisions regarding global budgeting for aggregate medical expenditures are made by society through the political process.

This critique exerts moral force in that it shows how a purely market-oriented solution, even if it curbs consumption and lowers some health-care costs, will not address more fundamental, underlying problems relating to well-being. Access to health care will remain largely a function of ability to pay, and, unless the impact of the new competitive model is dramatic, many will still lack access to life-saving and rehabilitative services available to the more fortunate. The result may be increased productive efficiency unaccompanied by a substantial increase in actual well-being. An alternative mode of allocation, one more sensitive to medical need than ability and willingness to pay, might score more points with policymakers, were improvement in well-being used as the standard measure for assessing alternative health-care proposals.

In addition, even if we adopt a market-based approach to health care, we will still face non-market allocation decisions for those who are willing but unable to pay for beneficial medical services. If we provide those services

52. DANIEL CALLAHAN, SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY (1987).
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through some supplemental public insurance program, then we still must decide, as a society, which services such programs will provide. This prospect raises profound concerns about the fairness of a two-tier approach that leaves the level of health-care coverage for the least well-off to the good will of the rest of society.

Finally, the non-market view challenges us not only to reassess how rational resource allocation may be achieved, but also to reconceptualize the notion of rational resource allocation altogether. In short, it makes the compelling case that efficiency, in none of its interpretations, constitutes the sole value—nor even the most important value—we should prefer in evaluating alternative social arrangements.

B. Market and Non-market Alternatives for Health-Care Allocation

Proponents of market-oriented health-care reform plans make the case for market allocation of medical goods and services by relying on a number of assumptions. Most importantly, they presume that the market for health care approximates the ideal market (i.e., one that reaches a Pareto optimal equilibrium state). Putting aside the various theoretical conceptions of efficiency criteria, we thus need to identify certain conditions a market for a particular good must satisfy, if a successful defense of medical markets is to be made on efficiency grounds.

Several features define the ideal market. First, potential consumers possess perfect information about the quality and costs of goods and services, and potential producers have full information about the costs of alternative means of production. Secondly, consumers are perfectly rational in the formal sense (they are capable of generating a rank ordering of their preferences for various goods and services). Third, certain facts about the larger context in which producers and consumers enter into exchange are assumed: that the transaction costs (e.g., costs of enforcing property rights and enforcing contracts) are zero; that perfect competition exists (i.e., no one party to an exchange can unilaterally influence prices); that parties are completely free to enter or leave a market; and that all gains and losses of individual well-being (positive or negative externalities) are accounted for in the market exchange between parties to a transaction.

To be sure, no actual market has the characteristics of the ideal market. Consumers and producers lack perfect information; the costs of enforcing contractual and other legal rights often are high; some parties may have a substantially greater ability to influence prices relative to others; and the well-being of other members of society (who are not parties to transactions) may be favorably or adversely affected by the actions of buyers and sellers. Yet the case made for market allocation on efficiency grounds rests either on the
assumption that free markets do approximate the outcomes of ideal markets, or that markets can be modified to approximate Pareto optimal outcomes.

Arguments based upon the extent to which actual markets sufficiently approximate ideal markets are often much too speculative to yield decisive answers about the desirability of market-based policy options. Nevertheless, they do provide at least some relevant considerations for evaluating the potential consequences of treating various goods as market commodities. The task of the remainder of this section is to review briefly two areas of concern in the debate for and against markets in the allocation of health care: (i) adequacy of information; and (ii) transaction costs.

At the core of the defense of a market approach to production and distribution of health care lie the following claims: that both consumers and producers have sufficient information to make informed, rational choices about medical goods and services; and that the cost of obtaining such information is not excessive. For this defense to carry weight, then, producers must have sufficient information about consumer preferences and about alternative means and costs of production; and consumers must have information about what kind of health-care services they are most likely to need, which preventive measures and treatment options will be available to them, which ones will most likely be beneficial to them (including the likelihood of their success), the risks and benefits of alternative treatments or no treatment, as well as the health-care providers who are best qualified to treat them. The technical character of medical information presents a significant problem, however, for a theory that assumes that efficiency may be obtained through the market mechanism. Information about cost as well as quality may often be difficult to obtain, since for many medical conditions providers cannot feasibly specify a price in advance of service; meanwhile, and more importantly, most consumers lack the information to make decisions about either the quality of alternative treatments or the competence of particular providers.

One set of market-based health insurance plans proposes to alleviate consumers' informational problems by injecting competition into the medical information industry (i.e., increasing available information through advertising, public health awareness campaigns, and expanded public access to disciplinary and quality assessment evaluations of health-care professionals, etc). But these proposals may involve substantial costs and in many instances may not provide reliable or relevant information. Anyone who has encountered the bewildering array of information presented in the process of obtaining informed consent for medical interventions can attest that the exigencies of modern medicine virtually ensure that information asymmetries will exist.

The managed care alternative discussed earlier implicitly acknowledges these difficulties by shifting the focus of consumer choice away from particular
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medical procedures and practitioners onto the aggregate range of medical conditions and services for which individuals would insure themselves.\(^5\)

Non-market alternatives to health-care delivery approach problems of consumer choice differently. Proponents of the national health insurance model, for example, doubt the capacity of individuals to make choices (in the aggregate) about what services are most important to cover and which forms of treatment are most beneficial. They therefore propose to establish universal health-care priorities through the political process. These single-payer advocates appear notably more sanguine about the adequacy of information necessary for individuals to make informed rational choices about providers.

Critics of the single-payer approach argue that the government is less well-informed than individuals about medical issues affecting individual utility. To the extent that such critics base their objections to the national health insurance proposals on grounds that expanded consumer choice begets efficiency, it would appear that they, too, must suppose adequacy of consumer information in the choice of providers (in as much as they favor freedom of choice in this area as well).

The adequacy of health-related information bears even more connection to the issue of transaction costs. The real costs of any market exchange or transaction reflect more than the costs associated with the production of particular goods and services. This holds true especially in the context of health care. What we traditionally think of as "health" costs actually comprise a variety of other costs, including the costs of administering insurance (in the form of endless paperwork) and the costs of the legal system (in the form of contract enforcement and compliance with governmental regulation).\(^4\) Many argue against such excessive paperwork, government regulation and medical malpractice laws on grounds that they constitute transaction costs that reduce efficiency. Although economists disagree about which costs are true production costs and which are transaction costs, they generally agree that transaction costs give rise to inefficiencies by ratcheting up the basic cost of production. Information costs alone add substantially to overall costs, whether they are borne by providers (e.g. through advertising) or by consumers, who must invest time and energy in becoming "informed" consumers (e.g., by reading medical journals for the latest evaluation of the efficacy and safety of hypertension drugs or, for corporate executives, by shopping for health benefit packages for their employees).

In addition to objecting to government determination of health-care priorities through democratic procedures on grounds that government lacks adequate information about individual utilities, market supporters often point

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53. See supra text accompanying notes 51-52 for discussion of managed care.
to the high costs of obtaining information for government-made decisions. They worry that the task of gathering information relevant to treatment priorities will be costlier for government than it is for individual consumers and providers. Market opponents respond that total costs are likely to be lowered either by employing economies of scale achieved by a single source of information gathering and assessment by persons with superior medical expertise, or by eliminating the costs associated with the propagation of false or misleading information by firms having a financial interest in promoting their own (putatively) therapeutic product.

Close to the problematic costs of medical information stand the costs of medical decision-making. For instance, critics of centralized political decision-making often point to potential inefficiencies of the democratic process. They note the high costs associated with deliberating, encouraging and responding to public participation, as well as with bargaining, negotiating and compromising among competing interest groups and health policy constituencies. Furthermore, irrespective of the decision-making process, potential delays in implementing decisions regarding the appropriateness of new therapies might also generate additional costs in a single-payer system of health care.

One of the most controversial issues relating to transaction costs involves the costs of government interventions in a health-care market in comparison to the expenses of government administration of a national health plan. Advocates of national health care argue that the existence of more than 1400 private insurers—each with its own list of covered services and medical conditions, criteria for reimbursement, and procedures for apportioning reimbursements among coinsurers (other parties who pay a portion of the total costs of services)—constitutes an enormous source of administrative waste that could better be used to deliver medical services. The contrasting view holds that government will waste even more resources and will generate greater long-run economic losses.

Although largely based on an empirical question, the controversy described above is also an evaluative one about what constitutes waste and about which other values each administrative system serves. Some might argue, for example, that a private system requiring a high degree of documentation for cost control will, in the long run, prevent wastes of other sorts, perhaps by more effectively discouraging provision of unnecessary services and by holding individuals more accountable for their health. Others might argue the opposite (i.e., that market insurance schemes will, in the long run, generate more waste than a single-payer system). Not ordinarily reckoned in these debates, however, are questions relating to the interface of economics and individual privacy.

55. See, e.g., BUCHANAN, supra note 20, at 29-32; MISHAN, supra note 13, at 161-163.
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For instance, is it more likely that personal medical information will be revealed to the economic and emotional detriment of patients if that information is widely shared among providers and insurers (the proposal for national data banks); or is the threat to individual privacy greater under the record-keeping arrangements of a unified national health system? Under which system will the procedures for safeguarding privacy of confidential medical information cost more? These questions have no easy answers, but they reflect the extent to which our judgments about what constitutes waste depend heavily upon the additional social goals we think important enough to warrant additional expenditures of resources.57

In short, although arguments about transaction costs are primarily economic and empirical in nature, they ultimately depend upon inherently evaluative judgements about which consequences ought to be taken into account and which assumptions ought to be made in assigning economic value to them. When considerations such as privacy, patient satisfaction, and impact upon consumer and provider behavior are taken into account, capacities of moral imagination and sensitivity matter at least as much as accounting skills.

To summarize the discussion to this point: the Pareto account of efficiency presupposes some highly controversial value assumptions that undermine any priority claim for efficiency over other social objectives. If Pareto efficiency criteria are subject either to utilitarian or equity objections of the sort I have outlined, then it is true neither that efficiency is the sole criterion of rational public policy choice, nor that considerations of efficiency ought to dominate our decision when conflicts with other values arise. Even if the market is the institutional arrangement best suited to the promotion of Pareto efficiency, it is open to question which set of institutional arrangements best satisfies the mix of competing values society might wish to promote in the allocation of health-care goods and services.

III. AUTONOMY: THE MORAL SIGNIFICANCE OF CHOICE

In the debate over health-care finance reform, there is general agreement on the moral importance of promoting respect for individual autonomy and freedom of choice. Accordingly, advocates consistently claim that their plan preserves these values, and that all alternatives undermine them.

57. For a discussion of the current state of confidentiality protection laws, their problems, and the range of moral interests at stake in fashioning public policy, see Madison Powers, Legal Protections of Confidential Medical Information and the Need for Anti-Discrimination Laws, in AIDS, WOMEN AND THE NEXT GENERATION 221 (Ruth Faden et al. eds., 1991).
A. Freedom of Choice and Market Theory

Proponents of markets in general have hypothesized that freedom of consumer choice is instrumental to achieving efficiency, and that markets tend to expand the domain of individual choice. They argue that markets generally increase individual choice by creating incentives for producers to find alternative, less costly ways to produce particular goods and to lower prices on particular goods.

In a number of important respects the market for health care does not fit the standard market model of consumer choice. Health care is not a discretionary item for which consumers are free to enter and exit the market at will. It is a basic, essential need; and more importantly, among essential needs such as shelter or food, it is not one that most persons can budget for by computing eventualities. Health-care needs are often intermittent in character, unpredictable in onset, and extremely expensive. Even the most conscientious—and all but the most affluent—are unable to pay for many medical bills out of current household earnings or savings. The total costs of many major medical services frequently surpass the costs of a down payment for the purchase of a home (itself an expense that many cannot afford and many others can afford only after years of saving). Consequently, the market for health care has become largely a market for insurance, rather than a direct market for services.

Although consumer choice may expand when the market allocates many other goods and services, markets for health insurance can potentially limit consumer choice in unexpected ways. The restricted nature of individual choice attributable to the present structure of the health insurance market has its roots in at least five major sources.

First, as discussed in Section II, those who are unemployed or employed by firms not offering health insurance benefits often have no feasible option to purchase private insurance (due to the even higher costs of personal medical insurance). Even where states offer those not eligible for group insurance the opportunity to enroll in pooled-risk plans, the costs of such plans remain virtually prohibitive for the lower-income workers who typically occupy jobs that provide no health benefits. Moreover, the financial burden of this disparity in access to affordable insurance falls disproportionately upon segments of the population that are more likely to be unemployed or employed in low-paying jobs where insurance is not provided as an employee benefit.  


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Second, for those covered by traditional health insurance, which pays all or a substantial portion of the insured's medical bills, there is little or no direct incentive to be cost-conscious. Insurance premiums are paid regardless of whether the policy is exercised, and therefore the normal market expectation that individual choice (or willingness to pay for services) will limit costs cannot be met. Without the important role of consumer choice as a means of lowering cost, the exercise of consumer choice also may not produce the kind of competitive consequences that would further expand the range of consumer choice.

Third, the amount of selection among insurance benefit packages offered through employment typically depends on the number of employees, the nature of the work performed, and personal characteristics of particular employees. Firms with fewer employees may find it impossible to offer a range of plans, and many smaller firms may be able to provide only one plan—or no plan at all—for their employees. Employer-provided insurance is priced according to an experience rating, which means that the affordability and number of insurance plans available may be considerably less for more hazardous occupations such as mining, heavy industrial manufacturing, or gasoline service stations. In addition, the options of individual employees—as well as privately insured individuals—may be limited by virtue of their own health status. Individual medical underwriting limits the opportunities of privately insured persons, and, as mentioned earlier, even employers who self-insure or obtain group insurance have incentives to engage in exclusionary practices designed to lower the overall costs for the group. Thus, those with expensive preexisting medical conditions may find it difficult not only to get insurance but also to get jobs.

The consequence of making insurance available primarily as a function of the consumer's characteristics (rather than characteristics of the goods and services themselves) is that individual choice does not play the role it is hypothesized to play with the market mechanism in place. Because insurers maximize their profit potential by excluding or restricting certain potential purchasers from the market (rather than by producing the same or superior product at a reduced cost), many consumers receive neither the benefits of reduced costs nor expanded choice of medical goods and services.

Fourth, consumer choices may be restricted due to reliance on an employer-mediated insurance market. Both employer and employee have a substantial interest in reducing health insurance costs, in as much as high insurance costs erode wages and employees often pay some portion of the insurance premium. Although employers and employees generally share interests relating to obtaining affordable health insurance, their interests with respect to matters of freedom of choice may radically diverge. The employers' imperative? Cost control, undoubtedly. Thus, the high cost of providing multiple options impels them to limit the choices available to their employees. An analysis of recent trends suggests that the number of insurance options
made available through employment is decreasing rather than increasing, even for employees of large firms. Employers' preoccupation with cost control also may encourage them to make available only those plans—such as HMOs and other managed care plans that hold down costs—in part, by restricting the patient's choice of physician.

Fifth, individuals who obtain their insurance through employment may experience a substantial loss of autonomy in matters indirectly related to their insurance plan options. Because insurers seek to limit their losses from adverse selection (consumers with higher anticipated medical expenses make sure to purchase inclusive insurance coverage) standard insurance policies contain provisions limiting or excluding coverage for preexisting illnesses. The effect on individual choice: such employees effectively cannot change employers without fear of losing their insurance coverage. Consumers are thus made captive to both particular employers and insurance companies, as overall autonomy declines.

B. The Main Ingredients of Market Reform Proposals

There are two basic proposals for expanding consumer choice among insurance benefits packages through market reform. One strategy would remove financial incentives for insurers to discriminate against potentially costly consumers (i.e., segmenting a community of insureds into risk-specific pools). This strategy favors prohibitions on exclusion from insurability on the basis of employer characteristics (e.g., experience rating) or medical status of individuals (medical underwriting), as well as a ban on pre-existing medical condition provisions. The effect, if such reforms were fully implemented, would be to make consumer choice a function of the features and price of the product sold, rather than a function of the characteristics and circumstances of the consumer. The insurance companies would set their rates on the basis of the average level of risk associated with a particular community of potential insureds (community rating), and consumers would be free to choose among various alternatives without regard to their connection to employment and without being locked into their current insurance arrangements. Thus, these market reforms are designed to bring the health-care market closer to the traditional market model, so as to reap the anticipated benefits of expanded consumer choice.

60. See Etheredge, supra note 32.
61. Experience rating technically refers to a rate based upon the actual cost experience of a particular group. The experience history of one employer serves as the basis for setting rates industry-wide where there is no actual experience rating for that employer. Insurers make use of actuarial rate books which provide the basis for estimating costs for employers within a type of industry.
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It is important to realize how this change would affect both consumers and insurers. Traditionally, insurance was sold under conditions of imperfect information: neither consumer nor seller had information about who ultimately would have the greatest need for health services. The advance of medical knowledge has changed this feature of the insurance market radically. The progressive stratification of the insurance market on the basis of predictable differences in need has meant that some consumers effectively have been excluded from the medical-care market, while others have obtained a virtual windfall: indeed, young, healthy and high-wage consumers are now able to purchase insurance at rates lower than what might be available to them in a market in which risks were not differentiated. How do market advocates propose to counter these trends? They may require well-insured consumers to pay more than they do currently, so that uninsured and underinsured consumers may have expanded options for obtaining affordable insurance.

Market reforms of this sort alone may not fully achieve the cost-control benefits generally associated with the market mechanism. Increased competition through expanded consumer choice may well be expected to make insurance rates more competitive, and thus less costly in the aggregate. Nevertheless, one crucial difference between the market for health insurance and the market for most other goods and services remains: the consumer of medical care is not buying the ultimate good directly, but rather is indirectly purchasing a promise to pay for health services delivered by others. Consequently, health insurance is a somewhat unique market good: neither the consumer nor the seller is fully able to control the ultimate cost of what is purchased. Consumers purchase health insurance without knowing in advance of purchase what they will ultimately receive should they need medical services (e.g., what therapies are covered and at what rates insurance companies will deem the usual and customary charges for which they will reimburse patients). Insurers, meanwhile, are far less able than most firms to exert the kind of cost control that would allow them to set their prices.

In light of this unique feature of health care, many proponents of market reform have argued that a second strategy is needed to allow choice to play its desired role in controlling costs, and to allow consumers to choose more effectively from among an expanded list of insurance options. Hence the proposal to encourage the growth of managed care plans such as HMOs. Advocates identify two major benefits of HMOs. First, managed care plans are designed to control expenses by fixing the costs of medical services through arrangements that allow insurers to have greater control over the services offered and fees charged by providers. Second, managed care options are likewise defended in terms of their effect on individual choice. In many instances, the introduction of managed care options has in fact resulted in
greater availability of policies offering a richer package of benefits at some
cost savings, and expanded consumer choice among insurance plans.

Managed care plans nonetheless limit the consumers’ freedom of choice
in the selection of providers, and thus raise a number of ‘difficult questions
about the moral significance of choice. If, as advocates of the managed care
approach anticipate, consumers will have more choices among coverage
options, then is their expanded choice among plans more important than their
freedom to choose among physicians? The ultimate answer to that question
depends on a variety of considerations.

What, for example, makes freedom of choice valuable? If one’s view of
the moral significance of choice lies solely in the ability to choose without
interference by others, then more choice will always be seen as better than less
choice. But if one thinks that the importance of choice depends on other
considerations, more choice may not always be preferable to less
choice.\textsuperscript{62} What we in fact may regard as most valuable is an adequate range of choices
among truly valuable options rather than unlimited choice for its own sake.
If, for example, the cost-control constraints of managed care options substan-
tially interfere with sound medical judgment, then we reasonably may conclude
that getting more choice among less valuable options is not a desirable public
policy outcome. Or, if the proliferation of managed care plans makes compari-
son excessively difficult, we might not think that individual autonomy has been
increased in a morally significant way.

Ironically, those who argue against markets for health care may find
themselves caught in an awkward, perhaps even untenable, position: many
oppose such markets on the grounds that there are insuperable informational
barriers to adequate consumer understanding of the technical and scientific
nature of medicine, and yet also reject the managed care option on the ground
that it restricts consumers’ freedom of choice among physicians. People
holding both positions must argue that consumers lack the sufficient capacity
for autonomous choice about what kind of health plans they are most likely
to need, while also asserting that those same consumers have sufficient capacity
to appreciate differences among the services offered by different providers.
To justify this position, the market critics must explain how consumers are
better able to evaluate their best medical interests in the latter context than in
the former.

Yet this position (i.e., advocating greater freedom of individual choice of
physicians while rejecting expanded choice among health plans) may not be
so difficult to defend as one might imagine. The freedom to choose one’s
physicians may be uniquely related to individual well-being. It might be

\textsuperscript{62} See Gerald Dworkin, The Theory and Practice of Autonomy 62-81 (1988); Joseph Raz,
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claimed, for example, that freedom of choice with respect to physicians is more likely to encourage higher quality medical care, greater accountability of medical professionals to patient rather than corporate interests, a greater sense of trust in providers, and increased satisfaction in the overall health-care system.

C. Vouchers and Choice

Two other options for expanding choice in the health-care market merit consideration: a voucher system for obtaining health insurance, and a system of general income support vouchers allowing low-income persons to purchase essential goods and services which they cannot now obtain because of indigency.

President Bush recently proposed the establishment of a voucher system for obtaining health insurance. These vouchers would be made available to persons at or below the poverty level. They could be redeemed in the form of insurance policies purchased from insurance companies, and they would count as a credit against personal income taxes. The President’s proposal might appear strongly committed to both freedom of choice among providers and freedom of choice among insurance plans.

If such a proposal is to expand the options for low-income people to effectively choose their own insurance plans in the market, then at least four conditions would have to be met. First, the various market reforms designed to eliminate the substantial cost differential between employment-based insurance and private insurance would have to be fully enacted. Otherwise, it is unlikely for there to be a significant improvement in access to health insurance for those not in a group plan. Second, its success depends in large part on the effectiveness of other mechanisms designed to hold down medical costs. Third, plans that would allow individuals to buy insurance through state, private, or regional pooled-buying arrangements (Health Insurance Networks) would have to exert considerable market pressure on insurers to obtain competitive rates for those who exercise the voucher option. Lastly, the success of a health insurance voucher plan would depend crucially upon the public commitment to fund the tax credit system at levels high enough to expand the insurance options for the targeted population.

While the Administration’s proposal reflects a general commitment to freedom of choice of physicians, its resolution is tempered by its endorsement of managed care proposals as the primary vehicle for delivery of health care in public programs serving the poor. The proposal endorses a greater reliance upon managed care options for delivery of care to indigent and Medicaid populations, and as noted in the last section, such plans are meant to achieve cost-savings through restriction and control over the providers. The general
defense of a largely market approach (i.e., that markets will increase the range of choices to individuals) is fundamentally at odds with the plan's suggestion that Medicaid recipients should be served by programs that limit the patient's choice of health-care facility and provider. For if freedom of choice among providers is so valuable, then it is difficult to justify a system of health care in which the worst-off members of society possess the fewest choices.

Other voucher proposals designed to establish a system of general income support vouchers targeted at low-income persons raise additional issues, in terms of both respecting individual autonomy and enhancing the well-being of low-income citizens. If individual autonomy is deemed the primary value that any public welfare program should promote, then it is not at all clear that a system of vouchers solely for health insurance is, by that criterion, an acceptable public policy alternative. Charles Fried, for example, has argued that promoting freedom of choice is important because it is the way that society best shows respect for the individual as an autonomous moral agent.\(^6\) On his view, selecting out health care as a special welfare benefit that society will make available to its less fortunate citizens is unacceptably paternalistic, as compared with allowing individuals to allocate their own resources. Some might judge that what is most important is providing enhanced educational opportunities for one's children and, therefore, that a general income supplement voucher would better enhance the well-being of the worst-off members of society consistent with appropriate respect for autonomy.

The strength of Fried's argument depends on two crucial assumptions. First, it assumes that the only considerations of significant moral relevance in public policy decisions relate to the individual. Considerations of both the autonomy and well-being of those who are provided assistance are by his theory matters focusing solely upon the moral concerns of individuals. (As will be discussed in Section IV, there may be considerations having to do with communal values that are not appropriately reflected in this analysis).

Second, Fried assumes that the individuals targeted for public policy benefits are autonomous moral agents. Yet considerations of autonomy may be of little or no relevance in the assessment of public policy options. Not all of those for whom expanded access to health care is morally important are autonomous agents. The well-being of dependent children or spouses is not linked to their own choices but to the choices of others.\(^6\) The primary concern in design of a system of universal access should not be the autonomy of parents to decide what proportion of their income they will devote to the health care of their children. The primary concern rather should be ensuring that

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64. Allan Gibbard, Health Care and the Prospective Pareto Principle, 94 Ethics 261 (1984) (arguing that given the kind of social insurance it would be rational to prefer, a market of adults acting on their own behalf would not be adopted by prudent purchasers of insurance).
dependents who cannot make choices for themselves, and who must depend
upon others for such decisions, do not risk lack of access to health care
because of their parents’ imprudent decisions to spend their resources on other
goods. A general income voucher system, and even a health voucher system
if not utilized by parents or guardians, leaves the most vulnerable members
of society with the least assurance that their health interests will be served.
Any system that is avowedly committed to providing universal access to health
care, should not tolerate a plan that would have this result.

D. Choice and Entitlement Approaches

Proposals for a single-payer, universal-entitlement system similar to
Canada’s has very different implications for the value of autonomy. These
differences can be viewed against the backdrop of the market approaches.
First, a universal entitlement plan would preserve the individual’s freedom
to choose among providers of health care. Under proposals perpetuating the
dichotomy between public and private insurance plans, some consumers will
have far fewer options in the choice of a physician as long as public programs
continue to be underfunded. In addition, some who choose to enroll in man-
aged care options may lack the same range of choice among providers if their
selected programs restrict the kinds of covered treatments offered for the same
medical condition. Since consumers are unlikely to know in advance what
options may be available for the vast number of conditions for which they
might later need treatment, and because of differences in medical judgment
about the most appropriate course of treatment, access may be further restrict-
ed to some physicians who do not offer the form of treatment the managed
care plan covers. A universal entitlement plan removes such impediments to
patients’ choice of providers and related matters.

Second, under a system that sets a single schedule of reimbursement rates
for all services there would be no economic incentive for providers to discrimi-
nate against potential patients on the basis of insurance source or differences
in reimbursement.

Third, a universal entitlement plan could restrict the autonomy of persons
who wanted to receive or deliver services that are not provided under the
unified public plan. This result would obtain, however, only if the plan
prohibited individuals from spending more of their resources on additional
services or prohibited providers from making such services available. Certain
single-payer proposals do in fact allow individuals to supplement the basic,
universal health-care package with coverage for additional services.

The major potential threat to individual autonomy under the universal
entitlement system is governmental intrusion into the physician-patient rela-
tionship. An important consideration in choosing between a centralized collec-
tive decision-making system and a decentralized pluralist system is the question of its compatibility with a society characterized by value pluralism. A system that makes payment for services a matter for resolution through democratic processes has profound implications for controversies over which services are to be funded in a public system. The adoption of a unified public plan collectivizes decisions otherwise left to the province of individual decision-making.

In the resulting politicization of such decisions, we may be forced to confront issues on which there is little or no broad social agreement. Some will inevitably end up paying for things they consider morally unacceptable (e.g. abortions). Others will worry that the public program will not pay for services that they think are morally required. Payment for treatments such as nutrition and hydration for patients in persistent vegetative state (PVS) is a prominent example of the problem. Some citizens may view the preservation of life even for PVS patients to be morally essential, while others will think that paying for such services is irrational or even morally repugnant.

Still others may fear invasions of physician-patient privacy of another sort. The recent controversy over the extent to which the government may interfere with communication between physicians and patients is amply illustrated in the Supreme Court’s decision upholding a ban on abortion counseling and referral by physicians who receive Title X family planning funds.

Moreover, there are likely to be controversies about what constitutes an illness or medical need. Payments for in vitro fertilization or surrogacy are examples of the irreducibly normative aspect involved in determining what otherwise may appear to some as a purely positive medical judgment.

Even if agreement on what counts as a genuine medical need is reached, controversy will arise over establishing priorities for funding various needs. One likely controversy will involve the conflict between the use of various models of cost-effectiveness analysis and the input obtained through mechanisms of public participation. Cost-effectiveness models attempt to determine rational allocation of scarce resources by evaluating comparative health outcomes of alternative treatments. Such comparisons may in some instances be relatively uncontroversial in moral terms, even straightforward in terms of scientific merit, as long as the comparison only involves alternative means of treating the same medical condition. Those would be the easy cases. More

68. See John LaPuma & Edward F. Lawlor, Quality-Adjusted Life Years, 263 JAMA 2917 (1990); Danielle O. Emery & Lawrence J. Schneiderman, Cost-Effectiveness Analysis in Health Care, 19 HASTINGS CENTER REP. 8 (1989); MISHAN, supra note 13, at 110-115.
controversial moral issues might be presented, however, when some measure of health outcome (such as life years saved) for conditions that are relatively inexpensive to treat are compared with treatments that are more costly (e.g., per-unit of life years saved). The democratic process is likely to put various health concerns directly at odds with one another: pitting treatment of those with existing medical conditions against strategies for prevention of future disease; some types of illness against other types; and chronic care priorities against emergency care. Such a process could even lead to a weighing of the health needs that specially affect a particular race or gender against other needs. The recommendations obtained by cost-effectiveness analysis techniques will likely conflict with the priority demands of various groups actively participating in the political process. Who stands to lose most in terms of autonomy under the universal entitlement system? Clearly those who would prefer to purchase their own insurance that better reflects their own financial, medical, and moral priorities.

In addition, the choice between a universal entitlement system and a market approach raises difficult questions about the future role of alternative health-care providers such as feminist and gay men's health clinics, and community health centers with a focus on a broader or more specialized conception of health than the traditional medical model supposes. How will each approach affect the role of such revisionary forces in the evolution of approaches to health care and the ability of patients to expand their choices beyond those broadly represented within the traditional medical establishment? Will a single-payer, universal-entitlement system under democratic political control provide sufficient latitude in what will qualify for national reimbursement, or will its result be greater regimentation and fewer options for experimentation in the long run?

Alternatively, one might raise the same worries about the new market reform approaches if managed care options substantially displace the traditional fee-for-service system. Will medical-care facilities offering alternative approaches to health care be further marginalized without the ability of a critical mass of consumers to support them with the proceeds from insurance? As long as open-ended insurance programs allow individuals considerable freedom in the choice of health-care professionals and the style and philosophy of practice, individuals may have somewhat greater freedom to make bolder, potentially innovative, choices in the manner in which their medical care is delivered. But as long as comparatively underfunded public programs continue to exist, many who wish to try innovative approaches in medically underserved and economically disadvantaged communities will continue to compete with far fewer

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resources than are available to other providers. None of these questions is readily answerable in advance, but it is important to recognize that serious long-term concerns about patient autonomy are at stake in the choice to collectivize decisions otherwise now left largely to the province of individual decision-making.

Finally, the assessment of institutional alternatives for allocation on grounds of freedom of choice is further complicated by one's view of the moral importance attached to the different ways in which individual choices might be restricted. Put another way, is some restriction of individual choice resulting from deliberate governmental intervention morally better (or worse) than a similar degree of restriction resulting from the operation of market forces? Furthermore, every intentional governmental interference with the market has the potential not only to expand or contract the range of choices available to individuals, but also to alter the entire set of available options. If there truly is something morally worse about well-meaning but deliberate governmental interference with choice than there is with influence of powerful economic interests on individual choice, then policymakers cannot simply ask whether more or less choice will likely emerge from varying market or non-market policy options.

In summary, the universal entitlement alternative, as well as each of the market reform variations, reveal the extent to which competing considerations of autonomy alone fail to yield a single yardstick for selecting among health policy options. Which approach is preferable according to autonomy criteria will likely turn on an assessment of which choices we desire most. The decision between these two approaches to allocation of medical care, in connection with individual choice, will depend upon judgments about: (i) which choices we want most; (ii) which forms of interference, if any, we find morally more objectionable; (iii) whether or not we reasonably may prefer more choice to less choice given that many individuals lack sufficient basis for making medical choices (due to either medical or financial circumstance); and (iv) whether we rationally may accept some restrictions on choice in order to secure more or a different set of choices.

70. These concerns are considered in more detail in my *The Struggle Beyond the Struggle for Universal Access*, in *1 J. HEALTH CARE FOR POOR & UNDERSERVED* (forthcoming).
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IV. COMMUNAL VALUES

Neither arguments of overall efficiency nor arguments based upon the moral significance of individual choice have supplied decisive criteria for evaluating health finance policy options. Nevertheless, it is important to recognize a fundamental difference between the types of justification offered for market-oriented approaches to health care. Those who focus upon the moral significance of freedom of choice primarily concern themselves with protecting and promoting the rights and interests of individuals. By contrast, proponents of various efficiency criteria attempt to compare alternative institutional arrangements in terms of their impact upon the collective good of the community. The efficiency arguments focus on the realization of communal rather than individual objectives, and the comparison rests on purely economic terms.

This section examines additional considerations that differ in two important respects from those discussed throughout this paper. First, the arguments in this section involve non-economic community objectives not adequately captured in various accounts of efficiency. If some other aspect of the collective good may be adversely affected to a substantial degree by primary reliance on a market approach, then market approaches may be compared against universal entitlement approaches on grounds other than overall efficiency. Second, the case for universal entitlement to health care would gain support if one could supply an argument emphasizing communal rather than individual objectives. Accordingly, the defense of the entitlement approach would not depend so heavily upon the kind of individual rights arguments most frequently found in the philosophical literature.

Individual rights arguments typically premise the right to health care on the claim that because of its profound effect on one's well-being and individual life prospects, some level of basic health care should be allocated on the basis of need and not strictly on the basis of ability to pay. It is often argued, for example, that access to at least a decent minimum package of medical benefits must be a prerequisite to fulfilling any genuine commitment to equality of opportunity and that, because of the large and unpredictable nature of health-care costs, the lack of access interferes with the ability of individuals to pursue their own life plans. Market opponents, who focus upon the moral importance of equality of opportunity, and market proponents, who focus upon freedom of choice, thus share an important presupposition: both accept the idea that individual interests rather than collective social objectives are the most important considerations in weighing alternative policies.

A communitarian justification assumes that more is at stake than just the potential benefit to individuals in the form of increased well-being and en-

71. NORMAN DANIELS, JUST HEALTH CARE (1985).
hanced opportunity. It supposes that the provision of a basic level of health care is necessary for the promotion of other important social goals not reducible to the aggregate of individual benefits. It holds that universal access to health care is essential to the functioning of the community and to the achievement of societal as well as strictly individual goals.  

There are at least four different interpretations of how a communitarian argument for a universal entitlement to health care might be constructed.

The first argument might be called the social stability argument. On this view we might endorse the maintenance of a fairly significant level of governmental involvement in providing the social resources for meeting the basic needs of the worst-off members of society, notwithstanding our most fundamental value commitments: individual liberty, and, in particular, the overriding importance of the market as a means of preserving individual liberty. Indeed, we might feel that, in order to ensure a stable social structure necessary to preserve individual liberty, certain communal bonds must be preserved and reinforced even if by means other than the market. Hence the social stability claim that members of a community must share a sense of mutuality of concern for others as members of a common polity if individual freedom itself is to flourish. Those common bonds are broken and individual freedom is threatened when substantial numbers feel a sense of envy or a sense of unfairness in being forgotten or neglected by the more fortunate in society. An important social goal therefore must be to minimize the alienation and despair that leads to political unrest and to the destruction of liberty itself. Although the social stability argument assumes that the primary virtues fostered by market institutions are self-reliance and individual responsibility, it also admits that basic market institutions may need to be supplemented by other institutional arrangements to meet the needs of its members.

Although the value of a public rather than a private response to human need is purely instrumental to the preservation of individual liberty, the societal stability argument recognizes the moral significance of how the worst-off are provided for, as well as the value attached to achieving the desired outcome. A proponent of the social stability argument might reasonably claim that preservation of the fabric of social life may depend upon the type of institutional arrangements through which the needs of a society's members are met. Social stability may depend upon more than the provision for individual needs through individual acts of benevolence. It may be important to the preservation of the bonds of community, not simply that the needs of its least fortunate are met, but that they are met in a way which emphasizes the communal rather than the purely individual character of beneficence. If our overriding aim is

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to preserve individual liberty while maintaining strong allegiance to public institutions, then it is plausible to argue that commitment to those institutions is most effectively promoted when the needs of its members are met through collective action undertaken by government. Leaving the needs of the less fortunate to be met by private charity, for example, may reinforce in the recipients a sense that society has simply left their fate to the good will of the privileged few. A collective societal response to individual need, by contrast, affirms a stronger commitment to the well-being of its members, and it is likely to generate less fragile bonds of loyalty. If this is true, then we should value public provision for basic needs such as health care over the sum of individual acts of private charity meeting human needs at the same level of benefit to the beneficiaries.

A second form of the communal argument might be called the public goods argument. It claims that there are a variety of human goods for which we should not assume can best be provided for by individuals in pursuit of their own well-being in the market. Some have claimed that the health of the members of the community has the character of a public good.

The concept of a public good is one borrowed from the following economic theory: although the market is the best allocator of many commodities, certain goods cannot be fully realized unless they are provided for collectively. The classic example: clean air. The problem clean air and other public goods present for defenders of the market approach to allocation is that individuals are effectively unable to provide these goods for themselves, however much they may wish to do so.

Public goods possess three formal characteristics: they are non-divisible, non-excludable, and non-rival. Clean air is non-divisible in two senses. First, a consumer cannot simply purchase for herself whatever amount of clean air she is willing and able to pay for in the market. Second, she cannot effectively produce clean air without the cooperation of others. Unless others act—or at least refrain from polluting the air—she cannot obtain its benefit. Clean air is non-excludable in the sense that if one individual has the benefit of clean air, she cannot benefit from the existence of that good while simultaneously depriving others of its benefit. Clean air is non-rival in the sense that (at least in principle) the addition of more persons who might benefit from the good does not diminish the value of that good for each person. In short, either we all have access to public goods or none of us do, and the only way to provide them is through a collective decision process in which the level of desired goods is mutually agreed upon, as is a mechanism for social cooperation necessary for their production.

73. IAIN MCLEAN, PUBLIC CHOICE 11-12 (1987).
The claim that the health of community members has the characteristics of a public good is illustrated by the example of immunizations against communicable disease. We might protect particular individuals from disease by selective immunization, but to the extent the protection of each is intimately bound up with the need to immunize all, this is one form of health good that has at least the partial character of a public good. It is important to note, however, that even immunizations are not pure public goods as long as some may provide for their own benefit through their own activities, others may be excluded from benefit, and the value of the good an individual receives is not diminished by failure to provide similar benefits to others.

Those who, on the basis of the public goods argument, wish to claim that health care is intrinsically not a market commodity, strictly speaking, do not fully understand what a public good is. The pure public goods argument against market allocation is not simply that it would be better for everyone if certain goods were provided collectively (as in the case of immunizations), but that it is conceptually impossible to leave an allocation of certain goods to individual decision in the market.

Health care is a commodity more appropriately cast as a quasi-public good—one for which the benefit to each would be greater if it were not left strictly to market allocation. One way of illustrating the potential force of this point is through the example of emergency room closings. Because hospitals legally are obligated to serve persons with emergency medical conditions, regardless of ability to pay, the emergency room serves a conduit to expensive uncompensated care. Thus, from the point of view of hospitals who stand to lose money, it may be in their self-interest to shut down emergency rooms. Equally, it may be in the self-interest of other hospital patients who bear a part of the cost of uncompensated care through higher medical bills to have the emergency rooms closed. However, if enough hospitals in an area close their emergency rooms, there are predictably adverse consequences for persons who can pay for their own care. When they have a medical emergency, time may be of the essence in saving their lives; if the ambulance driver is told that all of the remaining emergency rooms nearby are saturated (ER SAT), then it may take an inordinate amount of time to get the medical care that they could otherwise obtain, given their own, more favorable financial situation.

This example demonstrates two points. First, arrangement of social institutions that leave access to health care to individual provision in the market may be individually self-defeating, even for those who can afford to pay for their own medical needs. All things considered, it may be individually rational to provide directly for the care of others, even if one is paying more for one's own care than would be necessary given one's relatively favorable position in the market. Moreover, even if some hospitals desire to keep their emergency rooms open, it is not rational for them to do so unless they can be assured that
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their competitors are doing so as well. Second, this social arrangement may
be collectively self-defeating in the sense that society overall is made worse
off. More people in the aggregate needlessly will die or suffer permanent
disabilities than if our social institutions were organized differently. Thus from
both individual and societal points of view, the preferred social alternative may
not be one that relies strictly upon the market approach to health care alloca-
tion.

The emergency room example is of limited consequence in as much as it
does not demonstrate that when all other benefits or harms are taken into
consideration, a market for health care will be either individually or collec-
tively self-defeating in its totality. The proponent of the quasi-public goods
argument might want to argue that there are many other instances of similar
(although perhaps not as dramatic) harms individually and collectively experi-
enced as a consequence of a market system. They might point to such things
as the ill effects of a unhealthy and unproductive workforce, the adverse
emotional and political consequences of unmet health needs in a market
system, etc. In addition, in order to make the case against the market, they
would have to show that overall and individual well-being could not be im-
proved unless the market is eliminated.

A third communitarian argument might be called the utilitarian argument
from social solidarity. Peter Singer, for example, argues that the best way to
promote the aggregate well-being with respect to health-care policies is to
make health care a matter of universal entitlement.\footnote{Peter Singer, Freedoms and Utilities in the Distribution of Health Care, in ETHICS AND HEALTH POLICY 175 (Robert M. Veatch & Roy Branson eds., 1976).} He suggests that given
the inequality of power and income in society, the only way that we are likely
to improve the well-being of the worst-off members of society (and thus raise
aggregate social utility) is by implementing a largely single-tier public system
of health care. Unless the powerful and affluent have the same stake in the
quality and availability of health care made available for the poor, the utilities
of the poor are likely to be lower, and the overall social utility is likely to be
lower as well. Singer qualifies his argument to some extent. He acknowledges
that a second tier of health care (available to those who have the ability to pay)
may be morally justified because it would produce still more utility. Neverthe-
less, he argues that in order for overall utility to rise, this second tier must not
represent such a substantial proportion of the total health-care system so as to
decrease the strength of commitment to the public sector.

These first three forms of communitarian argument are largely instrumental
justifications for non-market systems of allocation, or ones claiming that non-
market institutional arrangements contain greater moral value than alternatives
that rely upon markets. But none yet reflects what might be called the inherent
moral value of the community collectively providing certain goods to its members. The inherent value arguments concern the moral importance members of a community attach to the way the community expresses its most basic values through collective action, independent of any other valuable objectives that might be advanced instrumentally.

A distinction between two concepts of civic virtue may help to illuminate the morally relevant differences a communitarian might claim as a basis for preferring one form of social organization over another. The arguments in the rest of this section are necessarily more suggestive than fully worked out, for there has been much less rigorous development of modern virtue theory compared to moral theories involving considerations of efficiency and autonomy. Nonetheless, my aim is to provide a glimpse of how new arguments might be developed in support of a universal entitlement approach to health care. But first it is necessary to sketch a rough outline of how moral philosophers understand the concept of virtue as it relates to individuals.

Although theories of virtue differ in details, the virtue of an individual is said to be a matter of individual character, or the kind of person one is. Moral theorists concerned about virtue often remind us that all important moral questions do not simply ask what one ought to do or what kind of outcomes would be best overall. We might be equally concerned with questions of how one ought to live, and with questions about the kind of person one wants to be. According to Bernard Williams, questions about the kind of person one wants to be shift the focus to the standards which agents use in moral self-assessment. Individual self-assessment involves a reflection upon the commitments that form the individual's most basic moral identity. The virtuous agent is one whose life reflects a consistent harmony between his most basic moral commitments constitutive of moral identity and his actions. Although the lover of peace, for example, may conclude that war is justified, he is keenly aware of how his decision undermines his commitment to being the kind of person he wants to be. He cannot maintain the view of himself as a peace lover when he habitually concludes that war is the appropriate course of action. Individual self-assessment thus involves a scrutiny of one's actions in light of one's professed commitments, and a persistent failure to bring one's actions into harmony with those commitments reflects badly upon the agent's character.

The concern for harmony between basic commitments and individual action may be applied to other virtues as well. For instance, all recognize the importance of benevolence, or the disposition to respond to the need of others, as one characteristic of a virtuous agent. Thus, the assessment of individual character on any theory of individual virtue must take into account the propen-
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ities of the individual to respond to and meet the needs of others. Individuals who persistently fail to act with beneficence toward others cannot maintain a view of themselves as benevolent.

This crude picture of the moral importance of individual virtue can be used to draw the contrast between two concepts of civic virtue. On one view, the moral virtue of a community might be understood by reference to the virtues of each of its individual members. To the extent that individual virtue reveals a society's commitments expressed through individual action, assessment of civic virtue is solely a function of the sum of all individual actions. Thus, we may characterize one community as superior to another in terms of civic virtue when more of its members reflect whatever mix of character traits a virtuous individual should exhibit in his or her own actions. Under this conception, the civic virtue of that community comprises the sum of individuals' personal individual acts of beneficence.

Alternatively, we might think that a fuller account of civic virtue lies beyond the sum of individual propensities to respond to and meet the needs of fellow citizens. We might think that assessment of a community's moral virtue should also reflect how the community collectively responds to the needs of its members. Just as each of us is concerned about her own individual character, and the kind of person she wishes to be, so too, might we have similar concerns about what kind of community we wish to be. Just as individual self-assessment involves reflection on the qualities that form our most basic moral identities—or the purposes and values that ought to be expressed in individual action—communal self-assessment involves the qualities which are constitutive of a community's most basic moral identity, or the purposes and values that ought to be expressed in collective action. Public moral identity therefore concerns the way in which we see ourselves collectively rather than individually; and the way we see ourselves collectively has to do with the way the values constitutive of communal moral identity are expressed in collective action.

If it is plausible to think of civic virtue, in part, as tied to some conception of a community's public moral identity as I have defined it, then (for the purposes of communal self-assessment), we must reflect on which purposes and values we should want expressed in collective action. We might compare individuals and communities with respect to the virtue of benevolence. Just as individuals who persistently fail to act individually with beneficence toward others cannot continue to regard themselves as benevolent individuals, communities which fail to act collectively with beneficence toward its members cannot maintain a view of themselves as benevolent communities. Just as individuals may lack the requisite harmony of commitment and individual action necessary for viewing themselves as virtuous agents, communities may lack the requisite
harmony of commitment and collective action to allow them to see themselves as virtuous communities.

Is there any evidence to support the claim that we experience a difference between individual and communal conceptions of virtue? Is it plausible to think that we apply standards of communal self-assessment that genuinely differ from the standards of individual assessment we typically employ? Although I can provide no definitive answer to these questions, there does seem to be some basis for thinking that many experience a special concern that the values we think constitutive of communal moral identity should be expressed through collective action. Consider a familiar example: we continually are reminded that only the United States and South Africa, among the industrialized nations, fail to provide a basic level of health care to all of their citizens. On the one hand, this might seem to be no more than a rhetorical device meant to embarrass or convey guilt by association. But there is another, equally defensible interpretation. The comparison exerts special sting because it reflects badly on the kind of society we are. It does not reflect upon the character of each of us as individuals; it reflects upon our character as a community. It does not signal a possible moral failure associated with any individual's action; it signals a possible moral failure associated with our society's collective action.

The further question is this: should we feel the sting of this comparison with South Africa? The answer depends in large part on the role one thinks benevolence should play in any legitimate account of civic virtue. Even though every theory of individual virtue reflects some commitment to individual benevolence as an essential element of one's moral identity, there is still plenty of room for disagreement about how that commitment compares with other elements. The same problem arises for the role of benevolence in an account of the elements of communal moral identity. We can contrast two very different views of communal moral identity in order to get a sense of the possibilities.

First, we might view the community and the institutions that give it its public moral identity as a system that serves primarily as a vehicle to constrain anti-social behavior of individuals, to minimize some of the least desirable effects of unrestrained competition, to protect against unwanted governmental interference with the individual's pursuit of his or her own plans, projects and commitments, and to resolve disputes among its members when the voluntary basis of cooperative endeavor breaks down. On this view, social institutions ought to function primarily as the means for preserving the conditions necessary for the individual pursuit of well-being. The purposes and values we should want expressed in collective action are ones that mobilize the members
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of the community towards mutual protection rather than provision of benefits. Beneficence plays little or no role in this account of civic virtue, and the failure to meet the needs of its members through collective action does not lead to a negative communal self-assessment.

On a second view of the public moral identity of a community, members of the community would view the value of their mutual association in a different light. They may view the aims of collective action as encompassing some common commitment to mutual aid, and not simply as mutual self-protection. The responsibility for promotion of individual well-being then becomes, in part, a collective one; and failure to discharge this responsibility through collective action results in a profoundly negative communal self-assessment. There may be a deep tension between the values that best express the community’s moral identity and the collective actions of the community.

These two models, of course, represent ends on a continuum of possibilities. Few communities view it as solely a matter of collective action and responsibility to meet all of the needs of its members, and few communities view the task of meeting its members’ needs as solely a matter appropriately left to individual self-reliance or individual beneficence. Given that no single criterion for public policy evaluation seems likely to provide us with sufficient grounds to favor one alternative over the others, however, the ultimate decision will turn in part on what consensus we reach on the kind of society we want to be. In choosing between market and non-market options for allocating health care, we must decide how much of the responsibility for the burden of facing illness, disability, and death should rest with the individual and how much should be borne through collective action. Matters of efficiency and autonomy surely will figure centrally in that choice. But a more fundamental debate about the nature of community will underlie much of what is said. An important task is to bring those assumptions out in the open for more careful inspection.

77. For an eloquent account of this kind of conception of community and its primary purposes, see Judith N. Shklar, The Liberalism of Fear, in Liberalism and the Moral Life 21 (Nancy L. Rosenblum ed., 1989)