Justice and Fairness: A Critical Element in U.S. Health System Reform

Paul T. Menzel

There are many reasons for dissatisfaction with current U.S. health care. One-sixth of the population is uninsured, costs are 150-200% of those in other economically advanced nations, and the quality of care, as measured by disease specific mortality and morbidity data, is rarely better and often worse than in others nations’ less costly systems. A case for reform can mirror any or all of these concerns: cover more of the population with insurance, control costs, improve the effectiveness of prevention and treatment. I argue that two of these goals — greater population coverage and more disciplined costs — gain a significant part of their justification from moral beliefs about justice and fairness.

On wider population coverage, I first develop an argument for mandatory insurance that begins with an observed fact about competitive markets for health insurance, so-called “market failure.” Next I develop an argument for mandatory insurance that begins with a different empirical fact — the legal requirement of access to emergency care regardless of ability to pay. Both arguments, I contend, depend on moral principles of justice and fairness widely shared in U.S. moral culture, including by many who see themselves as vigorous defenders of free markets. Finally, within the context of mandatory insurance thus established, I argue that the same moral considerations of justice and fairness make restraining care to be efficient and “costworthy” a matter of moral obligation, not merely economic benefit.

From Market Failure to Mandatory Insurance

The primary justifications of competitive markets are freedom and well-being. Markets generate higher well-being because competing producers are enticed to deliver higher quality goods at lower prices to consumers who demand sufficient quality and low enough prices to justify their purchases. Goods end up in the hands of those who sufficiently desire and need them, and resources are invested in producing things that people actually and sufficiently desire and need, as indicated by the priorities manifest in their choices. Overall value is thus maximized.

Sometimes in even truly competitive markets, however, optimal production and consumption is not achieved. Economists refer to such cases as “market failure.” The paradigm instances occur when production or consumption is distorted by “externalities.”

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Given the structure of market failure in health insurance, a solution is obvious: do not allow people to pick their time to get insured, postponing their purchase of insurance during the time when they think it to be a poor bargain given their current good health. People need to pay in all along. If the chain of events leading to market failure — the likely ill getting priced out of the market — is to be avoided, not only must insurers be barred from using pre-existing condition exclusions, waiting periods, and widely varying risk-rated premiums, but people must be required to have insurance.

Several classic types of market failure occur in health insurance. It can occur when insurers, fearful of “adverse selection,” hesitate to offer insurance because they know less about prospective subscribers’ risk of needing care than the subscribers do, but it can also occur for virtually the opposite reason, the ability of insurers to segment purchasers by the different financial risk the insurers know they pose. In a completely voluntary and fully competitive insurance market, insurers will offer lower premiums to those they discern to be prospectively less expensive. They will keep lowering that cost for the youngest and healthiest to the point where insurers can still profit on this segment of the population. Perfectly complementing this competition among insurers are the effects of subscriber demand. The youngest and healthiest, if they are not required to purchase insurance, can refuse to subscribe unless the price drops to a level proportionate to the financial risk they pose to an insurer. On the opposite, high-cost end of the market, insurers, if they do not have to cover everyone, will offer insurance to high-risk subscribers only at rates actuarially adequate to cover those subscribers’ high expense. Without healthier subscribers in the same pool, the cost of insurance to high-risk subscribers will skyrocket. The result is predictable: remotely affordable insurance will simply not be available to many of the most likely ill, those who most need insurance to protect against devastating expenses. To be sure, they will be offered more affordable prices for policies that exclude care for pre-existing conditions or preserve the insurer’s right to rescind the insurance when a subscriber incurs too much expense. Those policies, however, leave high-risk subscribers exposed to the very risks that the good we call “insurance” is designed to blunt.

One commonly proposed solution is to prohibit insurers from segmenting premiums, rescinding insurance, or excluding pre-existing conditions, thus creating “guaranteed issue” of insurance for a “community rated” premium. By itself this strategy utterly fails. The effect of such prohibitions, by themselves, is actually likely to be an increase in the ranks of the uninsured. They inevitably raise premiums for the healthier and younger segments of the population, who will then be even less likely to insure. Premiums for those who still do insure then increase even more, and we are into a so-called “death spiral” for insurance.

Given the structure of this market failure in health insurance, a solution is obvious: do not allow people to pick their time to get insured, postponing their purchase of insurance during the time when they think it to be a poor bargain given their current good health. People need to pay in all along. If the chain of events leading to market failure — the likely ill getting priced out of the market — is to be avoided, not only must insurers be barred from using pre-existing condition exclusions, waiting periods, and widely varying risk-rated premiums, but people must be required to have insurance.

A likely objection to this argument by market defenders does not work. Markets, their defenders are likely to claim, have never been presumed to guarantee that the goods traded in markets will be affordable to those who most need them. The point is partially correct, but it does not refute the previous argument. To be sure, the case for markets does not claim that they will comprehensively convey goods to all who need them most. Not everyone can afford a car, for example, and some who cannot, need one (for work in a rural area, for example). We do not therefore say there is “market failure” in automobile markets. The problem in health...
insurance markets, though, is deeper. Not many (not very many, at least) of those who most need and value a car are blocked by the effects of competitive supply and demand from purchasing an automobile. A competitive market, in fact, gets cars to many of those who most value and need a car better than any non-market system of production and distribution would. In health insurance, however, the very workings of competition predictably make the good of even basic insurance much more expensive for precisely those who value and need it the most. A real tension, therefore, does obtain between one of the primary reasons for using markets — the efficient, beneficial coordination of production and consumption — and the fact that in an unfettered competitive market, health insurance will inevitably be out of reach for many (even most) of those who desire and need it most.

The language of this argument, focused centrally on “market failure,” is the language of economics, and the argument’s launching point is an undisputed social and economic fact: unfettered competitive markets in health insurance generate market failure. This may make the argument appear not to need any moral premises, but it does. That it does is revealed by a simple query. Yes, a relevant sense of market failure characterizes unfettered competitive markets for health insurance: many who most need insurance do not get it. But why not let this failure lie where it falls? Many things may be inequitable in the way an insurance market plays out, including the lack of affordable insurance for those most likely ill. So what? If we try to proceed at this point without any moral claims, the argument for universal insurance starting from market failure will be blocked. Some moral principle is required, one that condemns the segregation of financial burdens between well and ill.

Such a principle is available. I term it the Just Sharing of the financial burdens of illness. It is particularly appropriate for the political context of health system reform, based as it is on a sense of relational justice widely shared in U.S. moral culture. First I state the principle, noting how it is adequate to push the previous argument forward. Then I articulate its basis in a more fundamental, widely shared view of relational justice.

Just Sharing can be stated thus:

The financial burdens of medical misfortunes ought to be shared equally by well and ill alike, unless individuals can be reasonably expected to control those misfortunes by their own choices.

The principle’s scope is moderate. It does not call for a general redress for natural misfortune, having us equalize the entire life chances of well and ill. Its goal is modest: equalize the financial costs of illness. In contrast to equalizing entire life chances, to a large extent this is readily achievable.

Just Sharing is incompatible with pre-existing condition exclusions, high degree of premium variation by subscriber risk, rescission of insurance when a subscriber becomes high-cost, and other market segmentation devices that inevitably arise in an unfettered competitive insurance market, creating market failure. If one only bars insurers from using these devices, however, then the “death spiral” for insurance begins: community-rated premiums lead even more of the likely well to forego insurance, which this raises premiums for remaining subscribers even more, and the cycle deepens. Basic insurance must be made mandatory for a competitive market to avoid leaving many of those who most need insurance high and dry. The heart of the moral objection to leaving many high and dry is that the likely well ought to contribute more to insurance than their individual risk situation alone warrants. That is, a good share of the expense of illness should be shared by well and ill alike.

Indirectly, Just Sharing bolsters another part of the full argument for universal access beyond barring market segmentation techniques and mandating insurance. For a mandate to be fair, premiums must be affordable. A portion of affordability comes from narrowing the permissible range of premiums between well and ill, a step directly supported by Just Sharing. Another crucial portion needs to come from subsidies to relatively low income subscribers not eligible for Medicaid. One might think of the subsidies that make a mandate fair as a less direct consequence of the principle of Just Sharing than the mandate itself, but the difference is slim. The two go hand in hand. Pragmatically, selective subsidies as well as the mandate are needed once insurers are barred from greatly different treatment of well and ill.

This principle of Just Sharing does not come out of moral thin air. It is the manifestation in a particular realm of life — illness and its prevention and treatment — of a more basic principle of relational justice that is more widely shared than the heated debates about universal access to basic health care might lead one to think. To see this we must enter the thicket of foundational controversies about justice.

If we probe convictions about the proper degree of equality in the distribution of life’s goods, we find two extremes. On the arch-egalitarian end stand those who strive for equal well-being or equal resources for all. Their position may have some intuitive attraction, but it encounters pointed objections concerning
incentives and differences in merit and desert related to varying investments of talent and effort.

On the other extreme stand arch-libertarians who argue that short of a contract, individuals have no obligations of justice to others; obligations never arise out of fate alone. Their position has some intuitive attraction, too, conveyed by a question they presume to be rhetorical: if through no act or oversight or inaction of yours, I am struck, say, by lightning, why should you be obligated to help me?

A strong response to this question, however, is available to remove its rhetorical power. Even in the allegedly individualistic U.S., few people think about the overall burdens and advantages in life along such strictly “separatist” lines, and for good reason. The burden of proof implied in libertarians’ rhetorical question can be flipped: if there is no relevant difference between people (for example, one person is no more deserving than another), why shouldn’t we be obligated to share in another’s most unfortunate, life-agenda-setting burdens? After all, being alive at all is a gratuitous fortune for each of us. On what basis, therefore, may a person legitimately complain if truly undeserved burdens get pooled in order to help equalize life chances and overall opportunities for well-being? Oblications of justice are simply not grounded only in contract by actual individuals from their existing natural situations.

Echoing this point is the fact that the vast middle ground of U.S. moral culture is occupied by a sense of justice in which some but not all burdens get pooled, some but not all inequalities of well-being are accepted, and a clear role for liberty and choice is preserved. An articulation of justice that fits this bill takes the label Equal Opportunity for Welfare (EOW):

People should not be worse off than others through no fault or voluntary choice of their own. Situations where people are worse off than others because of their own sufficiently blameworthy actions or choices are not unjust, as painful or compassion eliciting as those situations may be.

There is considerable evidence within U.S. health policy history that a view of justice implying and including Just Sharing is widely held. (a) One moral factor behind the existence of Medicare is the need for the likely well to share in the expenses of the more likely ill. Arguably, the elderly were the first segment of the population selected to receive a guarantee of comprehensive, affordable access because they have the highest predicted health care expenditures, expenditures that others should help share.

(b) Passage of the Emergency Medical Treatment and Active Labor Act in 1985 and its reaffirmation in the decades since involves recognition that the costs of treating a segment of the ill, nonpaying patients who present at hospital emergency rooms, needs to be borne by others. Funding is largely accomplished through cost shifting to insured paying patients, which in turn raises premiums for everyone who buys hospitalization insurance. Thus, predictably, most of the cost ends up being paid by subscribers who are less ill. Notably, no suggestions to repeal this law emerged from conservative voices even in the vigorous debates of recent years about health care reform.

(c) Another piece of recent evidence is perhaps the clearest because it speaks so directly to the issue of sharing between well and ill. Within the intense and fractious debates about health insurance reform in recent years, one of the very few elements on which conservatives and liberals alike seem to agree is that

The equal opportunity for welfare in this notion of justice differs from equality of welfare, though the opportunities to be made equal are still ranked by the prospects for welfare that they afford. Because it focuses on opportunity, not welfare per se, EOW preserves a considerable role for individual choice. Also, when applied to health care, EOW implies something like the principle of Just Sharing. Together they point toward sharing to rectify inequality when the factors that create it are beyond people’s control, as they also point toward tolerating inequalities that result from sufficiently blameworthy choices within people’s control.

While it certainly does require a crucial moral premise, the argument for mandatory universal insurance for basic care that begins with the fact of market failure is still a powerful argument. It is powerful because the moral premise it needs, the basic view of justice referred to above as Equal Opportunity for Welfare, is not only defensible philosophically but represents a very wide central range of U.S. moral and political values.
people should not be prevented by their health status from obtaining or maintaining insurance.

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From EMTALA to Mandatory Insurance

A second, more limited kind of failure also marks health care markets—not for insurance, but for the provision of care itself. In a society in which many are not insured, a significant number of people will arrive at hospitals in emergencies unable to pay. When hospitals are under little competitive pressure to offer the best prices to insurers to get the business of patients, they may choose to offer uninsured persons uncompensated care, recouping the cost by shifting it to higher charges for paying customers who are insured. Under competitive pressure, however, no hospital can afford to provide much of this uncompensated care unless its competitors do likewise, and most competitors will not unless they are required to. Thus, absent a legal requirement, even hospitals who are strongly committed to providing such care will be forced by the realities of economic competition to cease providing it.

Exactly this set of forces played out among U.S. hospitals in the 1980s. Collectively, citizens then had a choice: either watch most hospitals turn critically ill patients away, or level the playing field for the hospitals that want to provide such care. If the political process is indicative at all of public opinion, apparently most people regarded the former option as unpalatable: they did not want to live in such a society and thus chose the latter option. In 1985, reaffirmed in 1998, Congress passed EMTALA, the Emergency Medical Treatment and Active Labor Act, requiring all hospitals to accept non-paying patients for emergency care.

Therefore, by 1985 the U.S. had effectively instituted universal access not only to care generally for those over 65 (Medicare) but for people of all ages to one particular kind of care, emergency care. Guaranteed access to emergency care, however, if pursued by itself, has two predictable results. (1) People often substitute less efficient emergency care for the more effective and efficient primary care for which they are not insured. (2) Some who may have found insurance attractive if they knew they had to have it to obtain emergency care go uninsured, tempted by the assurance EMTALA provides. Many of them will eventually still be hit with emergencies and then be unable to pay. Their care will be funded in hospitals largely by cost-shifting to patients who can pay—largely, patients with insurance. Compared to their compatriots of similar economic circumstance who are insured, those who rely on the societal guarantee of emergency care free-ride.

Thus, at this point in the picture another moral claim has entered the ring, a claim about unfair free-riding. Upon it another argument for universal insurance can be constructed. That argument begins with the fact of EMTALA and the sustained refusal of society to retract its requirement that emergency care be provided regardless of ability to pay. The free-riding that follows can be prevented only by mandating that everyone have insurance for some significant scope of care. In articulating the argument I first lay out the status of EMTALA and some facts surrounding it; then I explain and apply a principle about free-riding.

Factual Dimensions of EMTALA

The EMTALA requirement of universal access to emergency care is not merely legal fact. Abundant evidence beyond the legislation itself reveals that it reflects a belief strongly embedded in U.S. moral culture: it is not acceptable for hospitals to turn away the uninsured in emergencies. Were a hospital to turn a person away and something significantly adverse happened to her, there is hardly a community in the country where the hospital would not then find itself in the local headlines, chastised in op-ed pages, etc. Moreover, no political opposition to EMTALA has developed on any significant part of the liberal-conservative political spectrum. No voice for its repeal appeared in all the contentious debates about health reform in 2009. The first and only voice of opposition came during one of the 2011 Republican candidate debates, and then only as a partial audience reaction that was not endorsed by any of the candidates. Despite the reputation of the U.S. as having a culture of hardened individualism, people are not prepared to see the uninsured turned away from hospital ERs.

A second fact is that when hospitals live up to the requirement, it is difficult for them to confine the care they provide to the ER. If patients are not kept on for further acute care, they will likely just show up again, incurring more emergency care for which they cannot pay. Because of EMTALA, therefore, much more uncompensated care than just emergency care gets provided. As much as $100 billion is annually “cost shifted” onto patients who can pay (most of them insured) without their consent. One study estimates
that this shift has led to an average annual premium for every insured family roughly $1,000 higher than their premium would otherwise be.9 The dimensions of the costs imposed on others are hardly minor.

A third factual aspect is the inefficiency created by isolated universal access to emergency care alone. People understandably rely on ERs in lieu of seeking out more efficient and effective primary care. The predictable inefficiency of overused emergency care makes the cost shifting caused by EMTALA all the more galling. It may be objectionable that those who incur great expense to purchase insurance end up paying noticeably higher premiums because others rely on EMTALA to the point of foregoing basic insurance. It is even worse that the money spent on much of the care that must be provided could achieve greater benefit at less expense through primary care.

To be sure, some people philosophically do not support EMTALA — strict libertarians, for example. An ethical justification for EMTALA can be provided, but the argument articulated here does not need to provide or assume such justification. The present argument’s starting point is simply that we live in a society in which EMTALA and its wide political and moral support is legal and social fact. Even those who believe EMTALA is not morally well grounded need to reckon with the further matters of unfair free-riding that arise in the longstanding, stable context of EMTALA.

The Unfairness of Free-Riding10
What behavior is properly termed free-riding? Free-riding — real free-riding — is assumed by definition to be unfair. The range of the term and the principle employing it must be delineated carefully. The formal principle can be referred to as the Prevention of Free-Riding (PFR), sometimes also known as the “principle of fairness.” It speaks to situations where people receive benefits without paying their share of expense:

A person should pay her share of the costs of a collective enterprise that produces benefits from which she cannot be excluded, unless she would actually prefer to lose all the benefits of the enterprise rather than pay her fair share of its costs.11

When people who do not pay their share of the costs of an enterprise cannot be excluded from its benefits, the benefits are “public goods.”

Eventually I apply the principle carefully to health insurance. For now, suffice it to say that PFR applies both to EMTALA in particular and to health insurance more generally. With EMTALA, the collective enterprise calling the PFR principle into play is living in a society in which people do not die on hospital doorsteps for lack of emergency care. With health insurance more generally, the collective enterprise is a society that embodies the principle of Just Sharing between well and ill and creates a minimum of security from the assaults of illness and its expense.

The second part of the principle is crucial: a clause about preference that conditions any claim that people should have to help pay the costs of a collective enterprise from which they benefit. Any reasonable statement of a PFR principle requires some such clause. I have argued elsewhere12 that the hypothetical preference and presumed consent of the person receiving the benefits, as in the version stated here, is the correct limiting condition. It is not the weaker condition of a people’s mere acceptance of the benefits.13 It is also not the stronger condition of people’s actual consent, unless consulting them for their actual consent is feasible and not prohibitively costly. The principle applies in circumstances where it is very difficult if not impossible to exclude a person from receiving the good at issue (that is, the situation involves genuinely “public” goods). The test the community must then meet if it is to treat people with respect as free and responsible individuals when it requires them to contribute their allegedly fair share is this: if push were actually to come to shove and people would absolutely have to pay in order to gain the benefits, then they would indeed choose to pay.14

Suppose, for example, that individual residents in the neighborhood of a park cannot feasibly be excluded from receiving many of its benefits, and suppose that they would in fact agree to pay their share of its expense if that were necessary to receive its benefits. Then, even if we can no longer feasibly ask their consent (by putting the matter to a vote, say, because the park already exists), we may compel them to pay their share of expense. It is not their mere “acceptance” of the park’s benefits (say, by not moving away) that justifies taxing them. It is the fact that, were they to have to choose between paying their share of the park’s expense or going without its benefits, they would choose to pay. Any argument that a person must pay her fair share is only as good as the descriptive accuracy of the claim that in fact she would agree to pay that share if she must pay it to receive benefits.

Then here is the rub: it is often difficult to be confident about such claims. We have trouble putting people to a true behavioral test of whether they will agree to contribute their share in order to avoid losing benefits. Since they cannot realistically be excluded from the benefits (that is, the goods are truly “public”), any consent we might attribute to them remains forever hypothetical. Moreover, even if we could exclude
people to give a sense of reality to the test, they may still be tempted to “hold out,” hoping both that others will come forth to get the collective enterprise off the ground and it will then be too difficult to exclude them. Unless we are going to turn a blind eye to free-riding, we inevitably have to depend on fallible judgments about hypothetical consent. We must, of course, make those judgments as accurately as we can.15

PFR as stated here is itself a fundamentally pro-individualist principle compatible with liberty emphasizing views of justice. In holding people responsible for the costs of the collective enterprises from which they benefit, PFR keeps collective solutions to human needs in tow, tying them tightly to people’s ability and willingness to pay their costs. PFR thus provides a strong connection between social arrangements and individual preference. It is a powerful principle in justifying social coercion of membership and contribution precisely because it fits squarely within a social philosophy that highly values individual liberty. Any sound argument for universal access to health care that employs PFR can thus appeal to a wide spectrum of political and moral opinion.

These general points about free-riding and coercion can be summarized. To allow free-riding to go unaddressed tolerates unfairness: people gain the benefits of valuable collective enterprises without contributing their share of those enterprises’ cost. Society may require individuals to contribute to a collective enterprise from whose benefits they cannot feasibly be excluded, unless they would actually prefer entirely forgoing the benefits to paying their fair share of costs. Ideally, those who are honest holdouts, for whom the benefits are not worth a fair share of costs, should not be forced to contribute, but several factors must also be considered before rejecting coercion: the difficulty of confirming that an individual really is an honest holdout, the degree to which honest holdouts still benefit considerably from the collective arrangement, and how close any alternative non-coercive arrangement comes to producing equivalent benefits.16

**Free-Riding and Insurance**

Several elements endemic in any situation where many people are insured while others are not trigger PFR arguments. Before delineating them, though, a historically contingent fact about the U.S. situation needs acknowledging for its role in driving the anti-free-riding argument for universal access in the U.S. With the passage in 1985 of the previously mentioned EMTALA,17 every U.S. resident is guaranteed access to emergency care regardless of capacity to pay. People considering the purchase of insurance can then see that even without contributing to their later care by buying insurance, some of their most urgent health care needs will still be met — ER care at least, and a good bit more as well. Hospitals find it virtually impossible to confine to the ER the care this legislation effectively requires, for patients not kept on for further care will likely just show up again later, incurring yet more uncompensated emergency care. Because of EMTALA, therefore, rationally self-interested hospitals end up providing much more than just emergency care. As previously noted, over $100 billion of care annually gets “cost shifted” onto mostly insured patients, causing roughly $1000 higher annual premiums for every insured family.18

The concerns about free-riding here are exacerbated by the predictably inefficient overreliance on emergency rooms that guaranteeing universal access to emergency care by itself creates. It may be understandable why a society unwilling to commit to universal access more generally would choose emergency care as one of its first steps toward universal access, but the inefficiency created by no equivalent access to primary care makes the cost-shifting that flows from EMTALA all the more galling and unfair. It is bad enough for those who incur great expense to purchase insurance to pay noticeably higher premiums because of cost-shifting; it is worse yet to realize that much of the money extracted from people to finance mandated emergency care could achieve greater benefit at less expense if used for primary care.
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Both in this specific U.S. situation with universal access to emergency care and about health economies where universal insurance is used more generally, a central question for the basic structure for health care then arises: should people be at liberty to go uninsured? From a perspective focused on liberty and responsibility, health care is a net good only insofar as people are willing to invest in it because it sufficiently contributes to their welfare. It might then seem that people should be at liberty to have not only as much but also as little health insurance as they desire, including none. This is debatable, however, because of free-riding.

Clear aside two cases from the discussion: people who could definitely pay out-of-pocket for any care from which they might later significantly benefit, and people who will not subscribe to even the leanest plan because they simply do not have the necessary resources after paying for more immediate needs. People in the first situation are not exposed by lack of insurance, and they do not risk imposing costs on others. People in the second situation, let us assume, are either provided basic insurance or the means to make it affordable. The realistic question then becomes, should people who can afford insurance but cannot afford to pay out-of-pocket for actual care they could end up needing be required to insure? I refer to the subset of such persons who would not purchase insurance of their own accord as “rejecters.”

When many insure but some do not, rejecters still benefit in numerous ways. They seldom see friends and relatives die or suffer for lack of insurance, and they avoid being pulled by powerful attachments into bailing them out. They also live in a more buoyant and healthy society due to the care that many of the insured around them more dependably get. Call these the interpersonal benefits of insurance. Suppose that when put to the test, many of these rejecters would be willing to pay a certain amount of their own resources if they simply had to in order to obtain these interpersonal benefits from others’ insurance. To the extent that these benefits are valuable to them, rejecters free-ride on other people’s decisions to insure.

A complementary point is that rejecters impose certain costs on others. An uninsured person presents others with torturous decisions about whether to bail her out when she becomes ill beyond her means. Suppose they do bail her out. If the moral and emotional pull on their heartstrings and wallets is a peculiar function of their individual values, it might be said that it is they, not the person who failed to insure, who bears responsibility. To the extent, however, that their anguish and cost is an eminently reasonable and expected reaction, and especially if the rejecter, too, would typically have the same reaction to such situations, then she is responsible, not they. With respect to the costs that rejecters shift to others as well as the benefits they unavoidably receive, rejecters typically free-ride on those who insure.

These facts are critical in building a prevention of free-riding argument against leaving insurance voluntary, but they are not sufficient. Delineation of the PFR principle in the previous section tells us that we must ask three further questions to determine whether we have the sort of free-riding that warrants correction by required contribution. (1) Does mandatory basic insurance to eliminate free-riding constitute at least a break-even arrangement for those who resist participating, or instead, are those who insist they do not want insurance “honest holdouts” for whom benefits are in fact not worth paying their fair share of cost? (2) If some are in fact honest holdouts, do they still benefit enough from widespread insurance that the value they receive is worth, or nearly worth, the cost they would be required to pay? (3) Can any alternate, non-mandatory arrangement create close to the same individual and social benefits as the collective enterprise that requires their contribution? All three questions can be answered in a way that supports the case for making insurance compulsory.

(1) For the U.S., addressing the first question involves reference to the existing guarantee of emergency care. The crucial question for determining whether going without insurance is morally objectionable free-riding is this: would rejecters prefer to go entirely without the benefits provided by both the guarantee of emergency care and living in a society where insurance is prevalent? The list of benefits rejecters have to be willing to forgo to escape the grasp of the PFR is long: guarantee of access to emergency and associated care even if one cannot pay, freedom from the anguish experienced as a spectator-citizen if hospitals were to turn emergency patients away at the door, freedom from the emotional and financial pressure to bail out friends and relatives, the “social buoyancy” of the healthier society.
which basic insurance helps to achieve, etc. It must be emphasized that this list of benefits is in addition to what persons would gain in their own security and direct care from any basic insurance they are required to have.

The especially tricky aspect of free-riding situations noted in the previous section also needs to be considered. Because there is no way to exclude people from public-good benefits, there is no actual behavioral test to which people can be put to detect their real answer to the crucial question. To see whether one would imagine it to be a good bargain, one can envision living in a society that has virtually no insurance and no guarantee of emergency care, but that is not a real test. No resistant person's actual choice can accurately tell us that her benefits from universal basic insurance fall short of her fair share of its costs. We can only give non-definitive answers to a question that is stubbornly hypothetical — that is, we can give at best only a well-educated guess.

We do have, however, some helpful indicators. EMTALA enjoys extremely widespread support, even from parts of the political spectrum where mandates on market participants are generally castigated; apparently people across the political spectrum put high value on not being rejected for emergency care in their own possible case and on living in a society where others do not risk such rejection either. Broader insurance for basic care also garners widespread support. Even the most conservative opponents of greater regulation and central government sponsorship do not denigrate insurance or say it does not matter that nearly a sixth of the U.S. population is uninsured; instead they laud the capacities of a reformed marketplace to deliver insurance and reduce the ranks of the uninsured. The most basic indication of all may be that many people of similar resources purchase their own insurance, thinking it cost-worthy even without taking into account any of the public-good benefits they would receive anyhow. Moreover, when people are exposed to very high premiums by becoming high-risk subscribers, they tend not to react passively. They often pay even hardship-causing premiums, complain bitterly, or lend their political support to efforts to reform insurance. When all these considerations are totaled up, only a small portion of those who reject insurance likely do so as genuine “honest holdouts” who legitimately escape the grasp of the PFR.

(2) Of course some rejecters undoubtedly are honest holdouts, and they qualify for that escape. Given the array of benefits noted above, however, it is likely that even for these persons, benefits come close to being worth fair-share cost. Even if they are genuine honest holdouts, they are still partial free-riders if they are required to pay nothing by way of contribution.22

(3) The prevention of free-riding argument for mandatory basic insurance will still not be persuasive if an alternative, voluntary arrangement comes close to achieving the same benefits. Does it? Some prominently proposed free-market alternatives that stop short of mandating insurance are clearly inadequate. A notable proposal by the U.S. Republican congressional leadership in fall 2009 would have reduced the ranks of the uninsured by only 3 million by 2019, leaving 52 million uninsured then, virtually the same percentage of the population as currently.23 More complete alternative proposals, by contrast, address the coverage of pre-existing conditions, provide much larger subsidy pools for high-risk subscribers (upwards of $15 billion annually), and revise the taxable income exclusion for employer sponsored premiums into a tax credit for everyone's basic insurance that would provide greater assistance to lower income subscribers.24 How comparatively effective such proposals would be in correcting market failure and reducing the ranks of the uninsured is debatable. In the less partisan atmosphere of the 1990’s, conservative defenders of a multi-payer market did not shrink from including compulsory insurance as necessary to avoid free-riding and achieve efficiency.25 A cautious conclusion is that in addressing insurance market failure, even the most comprehensive and aggressive of the not insurance-mandating, multi-payer market proposals of 2009-2010 would be no more effective, and probably less effective, than the soft mandate of the 2010 legislation. Whether the example of mandates one has in mind is the multi-payer insurance markets of countries such as Germany, the Netherlands, and Switzerland, or the proposals of conservative scholars such as Pauly et al. from earlier decades,26 a universal mandate of basic insurance is arguably better.

The prevention of free-riding, applied to markets for health insurance, thus justifies mandating basic insurance. Note that this argument is made entirely within the confines of a social philosophy of classical liberalism and a limited, consent-constrained theory of the state. A multi-payer competitive market as a viable option for the structure of a health care system thus gets modified, by elements within its very own philosophical tradition, into a framework for insurance as universal as that in any single-payer system or national health service.27

I have couched the two basic arguments for mandatory basic insurance as if their respective moral grounds — Just Sharing of the costs of illness and Prevention of Free-Riding — are independent moral principles.
They are actually close relatives. The notion of justice expressed in Just Sharing, based on the larger justice principle, Equal Opportunity for Welfare, expresses one aspect of fairness — fairness in the larger prospects of life, one might say. Prevention of Free-Riding reflects concern about a narrower slice of situations, but it, too, is focused on fairness. PFR is even sometimes referred to as the “principle of fairness.” Both Just Sharing and PFR are expressions of interpersonal, trans-contractual societal fairness. Both, moreover, explicitly incorporate considerations of individual responsibility into the core of their content. They are complementary elements in a larger coherent moral view. It is thus not surprising that the arguments about health insurance that each of these principles generates both have the same conclusion — mandatory, universal insurance for a basic minimum of care.

Obligatory Cost Control

When a health system employs mandatory universal insurance to provide a basic minimum of care, controlling cost becomes a matter of strong moral obligation, not merely a means of government budget solvency, general economic growth, or individual self-interest for a majority of the population. The same considerations of justice and fairness that justify an insurance mandate equally strongly demand cost constraint. In the U.S. currently, this is vastly under-appreciated as a dimension of the moral challenge of health care reform.

That said, however, constraining costs has to be a matter of great concern in any health care economy where insurance is prevalent. This is because of the powerful “insurance effect”: once patients are insured, whether in private or public arrangements, they as well as providers have strong incentives to use care even when its statistical benefits approach zero and its cost enormous. Insurance distorts patients’ and providers’ perceptions of the relationship between cost and value. Both their preferences for care will exceed what is costworthy.

To respond to this problem and assist in regaining some control over insurance-supported medicine’s boundless appetite for resources, patients and subscribers must see resource use from a longer temporal vantage point than simply that of the insured patient. Admittedly, the right perspective is not the perspective of a subscriber who is unable realistically to imagine what it is to be assaulted by illness, but the right perspective is also not that of someone who now thinks only as a “patient.” Since cost-fueling incentives are created by insurance, it is logical to start conceptually controlling the use of care at an early point in the process, insuring. Arguably, then, it is from the perspective of the “reflective subscriber” that we should make cost-value decisions. Patients and subscribers of integrity will not shrink from this challenge.

Providers must not shrink from it, either. Especially when their reimbursement arrangement is fee-for-service, providers working within a framework of prevalent insurance face enormous temptations to recommend and provide care down to the last thread of benefit, or even when a procedure is more expensive than its alternative but offers no greater benefit. Insurance has value to people because it protects against risk and spreads expense over time and population; it is corrupted when it becomes a license for providers to do whatever they think they can within their ambitions, laudable as those may be.
Exploitation of the leverage offered by the “insurance effect” by either patients or providers is unfair to those who fund and purchase insurance. In choosing to buy insurance as a vehicle through which to pay for care, people do not intend to allow spending without regard to the value it offers. To be sure, in a voluntary insurance framework one might argue that subscriber choice provides protection against the potential for exploitation; if it gets out of control, subscribers can decide to use less insurance to finance their care. When insurance is mandatory, however, this lever for policing exploitation is removed. Thus, provider and patient exploitation of the leverage provided by insurance is particularly unfair if insurance is mandatory.

Cost constraint will need to be pursued on various fronts. One will involve setting limits to the scope of the care covered under mandatory universal insurance. Often that scope is referred to as a “basic minimum” of care. No substantive work is done by the concept of “basic” itself. “Basic” and “basic minimum” do not help determine the scope of the care for which society is justified in mandating insurance. The logical order is the reverse: the content of “basic minimum” is derived from the moral substance of the argument for universal access. It will be discerned by asking what level of insurance, for what level of care, the society is justified in requiring people to purchase. That is, what care may a society use its collective coercive power to make universally accessible? This question does not ask simply what care is good or beneficial. That may be a much wider circle of care than a society is justified in requiring people to buy insurance for. Elsewhere I have detailed some of the specific categories of care, particularly primary care and preventive services, that the arguments for a mandate imply should be included. Here, in focusing on cost constraint, I discuss two elements, comparative effectiveness and cost-effectiveness, that speak clearly to the relative value of resource investments.

In any legal mandate, what an insurance plan must do to constitute a qualifying plan has to be stipulated. That is done by listing the “essential benefits” for qualified plans, typically stated in large categorical terms like “prescription drugs,” “rehabilitative and habilitative services,” “mental health services,” “preventive services,” “maternity, well-baby, and well-child care,” “durable medical equipment,” etc. This still leaves open the question of what care within these categories should be covered. What criteria are relevant in making such decisions?

One primary general criterion should be comparative effectiveness of the care. If a service or treatment that is a candidate for inclusion is not as effective as other options, or certainly if it is not effective at all, plans and providers have a moral obligation to be efficient in their administration of insurance and in their provision of care. This is exactly how various parties in European health care systems that provide care which is typically as effective as that in the U.S. but at little more than half the cost put the matter. The statement that “inefficiency is unethical” made by Marc Danzon, head of the WHO Regional Office for Europe, has become a kind of dictum in European circles. Efficiency is not a moral luxury. It is a moral obligation. People should not be required to share in its financing through mandatory minimal insurance. Powerful reasons for this lie in both the insurance mandate and just sharing between well and ill. Insurance is a pooling mechanism in which those who end up not needing care subsidize the less fortunate who do. To require everyone to be insured is an imposition on their choice, justified both by the need to prevent unfair free-riding when society has already guaranteed access to emergency care, and by the obligation of the well to share the financial burdens of the ill. Both considerations will be turned on their heads if patients’ providers recommend, and patients choose to receive, care that has been shown to be less effective than alternatives.

One can put the point more poignantly in the first-person. In contributing my fair share of the expenses of health care by paying premiums for mandatory minimal insurance, powerful reasons for this lie in both the insurance mandate and just sharing between well and ill. Insurance is a pooling mechanism in which those who end up not needing care subsidize the less fortunate who do. To require everyone to be insured is an imposition on their choice, justified both by the need to prevent unfair free-riding when society has already guaranteed access to emergency care, and by the obligation of the well to share the financial burdens of the ill. Both considerations will be turned on their heads if patients’ providers recommend, and patients choose to receive, care that has been shown to be less effective than alternatives.

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of free-riding that mandatory insurance is designed to prevent will have been replaced by a reverse exploitation.33 Another way of stating this is that obligations of the well do not plausibly include helping to pay for measures that do not actually help the ill as much as more effective measures. On the surface, just sharing is focused on the sharing of expenses, but the driving reason behind that focus is the goal of assisting the ill to gain better health. Financial sharing is wasted justice — no, it is no justice at all — if what is financed is known not to assist health.34 It is also hardly justice if we do not care to find out what is effective in improving health.

Directly related to comparative effectiveness as a primary criterion is a close relative: comparative cost-effectiveness. Suppose that for treating a given condition, two treatments are equally effective but not equally cost-effective; one carries higher cost for the same likely benefit.35 If I am required to contribute funding through mandated insurance, my assistance and investment is being partly wasted if it is devoted to care that is no more effective but costs more. If people are going to be required to share in the expenses of those who fall ill and need care, then plans and providers owe them a commitment not to waste their financial support. And covering less cost-effective treatments for a given condition, not just the more cost-effective measures for the same prospective patients, is — let’s be clear and accurate here — a waste. The clear implication is that plans and providers have a moral obligation to be efficient in their administration of insurance and in their provision of care. This is exactly how various parties in European health care systems that provide care which is typically as effective as that in the U.S. but at little more than half the cost put the matter. The statement that “inefficiency is unethical” made by Marc Danzon, head of the WHO Regional Office for Europe, has become a kind of dictum in European circles.36 Efficiency is not a moral luxury. It is a moral obligation.

To be sure, living up to this obligation and including in the universally accessible basic minimum only services that are comparatively effective and cost-effective requires caution. Comparative effectiveness research (CER) may not always show what treatments are best for exactly whom, but only give rise to further questions concerning for exactly whom the treatment is effective.37 CER could also lead to rigid practice guidelines enforced to the letter by insurance plans in reimbursement policies, which critics fear would threaten the “art” of medicine, discouraging providers from thinking of their individual patients as anything other than identical representatives of a statistical treatment/diagnosis group. Strong practice guidelines based on comparative effectiveness and cost-effectiveness studies could also discourage providers from considering a wide enough array of treatments for their individual patients; once they perceive a treatment that fits what appears to be their patient’s set of conditions, they will tend to fasten on it to the exclusion of a more refined discernment of conditions and possibly helpful alternatives.38

An intelligent defense of CER will admit its limits and the danger that it can be misused to create crude and overly rigid guidelines, but then insist that it can also be used to create sophisticated guidelines sensitive to the variations that the research itself has uncovered. For example, lumbar and cervical artificial disks might be covered, but only for patients under 60 and only at a single disk level, or lumbar fusion for uncomplicated degenerative disk disease could be covered, but only when multidisciplinary pain services have already been tried.39 The case for CER, moreover, is not just defensive. CER is positively needed to assist providers in best serving their individual patients.40 Without findings from CER, providers tread on what too often turns out to be thin ice, in a context where practitioners can be predicted to underestimate the limits of their knowledge, acting as they are with such strong desire to help their patients. To be of best service, practitioners need more evidence about real effectiveness, not less.

Some guidelines based on effectiveness and cost-effectiveness research ought to be connected to insurance coverage. If multiple studies show a treatment to be ineffective for a specific condition — arthroscopic surgery for osteoarthritis of the knee,41 for example — then why should a practice guideline not be fashioned to tell providers that their prescription of such care for that condition will not carry insurance coverage? What better candidate for exclusion can there be than a treatment shown to be ineffective for stipulated conditions by rigorous and multiple clinical trials? The result of compensating providers for such ineffective treatments within the scope of coverage by basic insurance will inevitably be that eventually some other effective services, or some people entirely, will be left out of basic coverage. And even if that is not the case, requiring people to purchase insurance that ends up covering ineffective services is unfair exploitation using the coercive power of the state.

The strong, vigorous defense that can be made for discriminating use of cost-effectiveness should not blind the public or policymakers to the mistakes and misconceptions that cost-effectiveness analysis (CEA) can involve if it is pursued crudely. When used to exclude and include treatments for different groups of patients, it will often harbor questions of inter-per-
personal “social value” that are more difficult to address with common-sense unanimity than are the questions of intra-personal individual utility within a prospective patient’s life that drive decisions among different treatments for the same condition. Erik Nord and others have pointed out numerous ways in which, unmodified, CEA that maximizes individual utility cannot be used in the more complex inter-personal contexts without running rough-shod over social values that people – individuals, not just “societies” – also espouse. Those social values incorporate concern for rescue, severity of illness, maintenance of hope, realizing individual health potential, etc. The fact that CEA can get greatly off track morally if it is not properly sensitive to such considerations is no reason, however, for rejecting all roles for CEA. Especially when the comparative study is about different treatments for the same condition and same patients, it is foolhardy, wasteful, and unfair to those compelled to buy insurance to ignore cost-effectiveness.

Summary and Conclusion

Two widely shared values in U.S. moral culture, the Just Sharing of the costs of illness and the Prevention of Free-Riding, pair with a general fact of health economics, market failure in insurance, and with a particular historical U.S. legal fact, EMTALA, to generate powerful arguments for making insurance for basic care mandatory and universal. These arguments of justice and fairness, however, get turned on their heads if mandatory insurance facilitates and protects inefficient and wasteful care. Providers and/or patients will then be exploiting the leverage of insurance to extract advantages that neither advance justice nor prevent free-riding. Discriminating and determined cost constraint, focused on at least comparative effectiveness and comparative cost-effectiveness, is a crucial component of a just and fair health care system.

Two widely shared values in U.S. moral culture, the Just Sharing of the costs of illness and the Prevention of Free-Riding, pair with a general fact of health economics, market failure in insurance, and with a particular historical U.S. legal fact, EMTALA, to generate powerful arguments for making insurance for basic care mandatory and universal. These arguments of justice and fairness, however, get turned on their heads if mandatory insurance facilitates and protects inefficient and wasteful care. Providers and/or patients will then be exploiting the leverage of insurance to extract advantages that neither advance justice nor prevent free-riding. Discriminating and determined cost constraint, focused on at least comparative effectiveness and comparative cost-effectiveness, is a crucial component of a just and fair health care system.

References

1. See F. M. Bator, “The Anatomy of Market Failure,” Quarterly Journal of Economics 72, no. 3 (1958): 351-379, for a seminal early article on the phenomenon. Bator’s definition is “the failure of a more or less idealized system of price-market institutions to sustain ‘desirable’ activities or to stop ‘undesirable’ activities” (at 351). He defines desirability in terms of maximum welfare, acknowledging the central theorem of modern welfare economics that “under certain strong [idealized] assumptions... the equilibrium conditions which characterize a system of competitive markets will exactly correspond to the requirements of Pareto efficiency” in which no one can be made better off in terms of his own preferences without making someone else worse off.

2. The classic discussion of market failure in health economics is K. J. Arrow, “Uncertainty and the Welfare Economics of Medical Care,” American Economic Review 53, no. 5 (1963): 941-973. Some goods, Arrow argues, are not “marketable.” This occurs when the existing market fails “to provide a means whereby the services can be both offered and demanded upon payment of a price.” For market failure in health care Arrow focuses his greatest attention on risk-bearing. “The ability to shift the risks of illness to others is worth a price which many are willing to
pay. Because of pooling and of superior willingness and ability, others are willing to bear the risks. Nevertheless...a great many risks are not covered, and...the markets for the services of risk-coverage are poorly developed or nonexistent..." (at 945). While Arrow here has in mind primarily cases affected by moral hazard and adverse selection, a few pages later (at 947-948) he anticipates additional types of market failure with an observation about people’s preferences for government taxation and expenditure. This would appear to be a preference for redistribution, but it can also be interpreted as “desire for insurance.” The subsidies...go to those who are disadvantaged in life by events the incidence of which is popularly regarded as unpredictable: the blind, dependent children, the medically indigent. He follows this (at 963-964) with further discussion of pooling. "Hypothetically, insurance requires for its full social benefit a maximum possible discrimination of risks. Those in groups of higher incidences of illness should [actuarially] pay higher premiums. In fact, however, there is a tendency to equalize...premiums, especially in the Blue Cross and similar widespread schemes. This constitutes, in effect, a redistribution of income from those with a low propensity to illness to those with a high propensity. The equalization, of course, could not in fact be carried through if the market were genuinely competitive....Insurance plans could arise which charged lower premiums to preferred risks and draw them off, leaving the plan which does not discriminate among risks with only an adverse selection of them." Thus the move to a more constrained market— the availability of insurance to all, not just those least likely to be ill – cannot be achieved in unconstrained market competition.

3. Either that, or everyone must be put in one pool – that is, a "single payer" insurance system. I will not pursue the single payer option explicitly in this paper. It, too, constitutes a solution to market failure. Single payer and mandatory multi-payer insurance are solutions for the same essential reason: all, the likely well and likely ill alike, contribute to insurance funding. If we are weighing the respective advantages and disadvantages of a system of many competing insurance plans compared to a single payer system, the previous discussion of the remedies for market failure implies that the appropriate comparison to single payer is not a completely voluntary and unfettered market, but a multi-payer system structurally adjusted to account for market failure – one with guaranteed issue, no pre-existing condition exclusions, relatively common premiums, and unfettered market competition. Advocates of a single payer system who cite the various ills of market failure sometimes fail to acknowledge that single payer is not the only way to avoid those ills.

4. Note several things here. (1) The argument conveyed in the rhetorical questions just asked does not amount to the claim that a person should take responsibility for another’s misfortune. It is only a claim that one should partially share the burdens of another who is blameless. (2) This sentence and the previous two constitute the heart of the philosophical argument against the strict libertarian view of distributive justice and for something like EOW (defined in the next paragraph). In so far as this is a reasonably strong philosophical argument for Just Sharing and EOW, the argument in this section is fundamentally philosophical. That should be kept in mind even as the case I develop in the rest of this section shifts to an appeal to a social fact about EOW – that something like it covers a very wide range of the moral views about justice held by the U.S. population.

5. The label EOW is used by Richard Arneson for his version of this view in “Equality and Equal Opportunity for Welfare,” Philosophical Studies 56, no. 1 (1989): 77-93, and “Liberalism, Distributive Subjectivism, and Equal Opportunity for Welfare,” Philosophy and Public Affairs 19, no. 2 (1990): 158-193. G. A. Cohen articulates a similar view in “On the Currency of Egalitarian Justice,” Ethics 99, no. 4 (1989): 806-944. EOW as stated here and in the view of Arneson and Cohen rests in a family of views referred to as “luck egalitarian” justice. In Health, Luck and Justice (Princeton, NJ: Princeton University Press, 2010), S. Segall provides an admirable summary of such views and states his own version: “It is unjust for individuals to be worse off than others due to outcomes that it would have been unreasonable to expect them to avoid” (at 13). The views are “luck egalitarian” because they all see justice not as generally equalizing whatever is the proper object of equalization in a theory of justice (welfare, for example), but equalizing it only in order to compensate for bad “brute luck.” Bad brute luck (e.g., being hit by a falling tree one had no reason to suspect would fall) is distinguished from bad “option luck,” luck that occurs in a chain of events in which one’s own voluntary choices play a role. Justice requires equalization only for brute luck, not bad option luck. Examples of the latter include buying many lottery tickets but not winning, or playing Russian roulette and ending up dead. A more debatable example that some would regard as bad option luck and others would not is becoming seriously diabetic after years of heavy sugar intake and modest obesity; though heavy sugar ingestion and obesity are well known risk factors for diabetes, most people who heavily ingest sugar and are obese do not develop diabetes. See Chapter 3 of Segall for an extensive discussion of bad option luck.


8. See EMTALA, supra note 6. See also T. M. Lee, “An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement,” Annals of Health Law 13 (2004): 145-178. An important element conditions the requirement: if another hospital designated and financed to provide care to uninsured persons is located within a feasibly safe transportable distance, then a hospital does not have to accept non-paying patients.


10. Much of this and the next subsection are adapted by the author from “Justice, Liberty, and the Choice of Health System Structure,” supra note 7.

11. PFB is often referred to in the philosophical literature as the “Principle of Fairness” or the “Duty of Fair Play.” See H. L. A. Hart, “Are Their Any Natural Rights?” Philosophical Review 64, no. 2 (1955): 175-191, at 185; R. Nozick, Anarchy, State, and Utopia (New York, NY: Basic Books, 1974): at 93-95; D. Schmitz, The Limits of Government: An Essay on the Public Goods Argument (Boulder, CO: Westview Press, 1991): 146; and the excellent survey of the philosophical literature by J. Morelli, “The Fairness Principle,” Philosophy and Law Newsletter, American Philosophical Association, Spring 1985, at 2-4. The “fair share” and “willing to pay” elements already cover the exemption from an obligation to contribute that obtains when people are unable to pay. In their case, either the truly fair share of payment is virtually nothing; or, given their meager resources, they would not have been willing to pay to...
get the benefits, and thus have no duty to pay just because we cannot now exclude them from the benefits. I do not attempt here a justification of PFR itself, in any version. It is possible that there are no more fundamental reasons behind PFR to provide its justification. It might be needed to explain why any moral principle can bind people at all: morality as a whole is the collective enterprise, and a reasonable degree of obedience is the fair share everyone is obligated to pay to gain the non-excludable benefits of morality as a social institution.


13. That it is not has been persuasively argued by Nozick, *supra* note 11, at 94.

14. For sometimes differing treatments of when free-riding is unfair (i.e., is genuine free-riding), see the various authors in *supra* notes 11 and 12.

15. If hypothetical consent has to be embraced to operate with PFR in the actual world, another difficulty in using the principle to justify coercion will still have to be confronted: some legitimate “honest holdouts” may remain, people who receive benefits from the enterprise less than their share of its costs. Coercive payment laudably catches many free-riders but in the real world will also likely catch some who really do prefer to forgo all benefits to paying their share of costs (see Schmidt, *supra* note 11, at $4). Why should they, too, have to fund what is then essentially other people’s chosen projects? Perhaps, then, all we need is a PFR principle that insists free-riding is to be regrettable, not one in which it is objectionable enough to justify coercively extracting contribution. Additional considerations, however, push PFR toward justifying coercion. (1) Honest holdouts and free-riders are not necessarily different people. If the good the collective enterprise produces is virtually universal, then even if one is an honest holdout because one judges benefit insufficient to balance fair-share cost, the matter may be a close call. And even if being an honest holdout should block enforced participation, the fact remains that if the enterprise proceeds and one is not required to pay, one still gets for free a benefit that may be nearly worth the cost. (2) Another balance-of-cost-and-benefit factor is also relevant: how close do the alternative arrangements of private contract and individual voluntary decision come to achieving benefits equivalent to those of the collective enterprise imposing contribution? The closer they come, the weaker the case for the collective enterprise and enforcing a contribution to prevent free-riding.

16. These conditions are elaborated more in Menzel, “Justice, Liberty, and the Choice of Health System Structure,” *supra* note 7.


19. Not only is the immediate moral call of rescue more clearly in play in emergency care than in most other care, but financial responsibility for mandating it can be rather conveniently dodged because “backdoor” financing is feasible. Emergency care is provided by sizable institutions (hospitals) large enough to absorb immediate costs and shift them. No such hidden financing is as feasible for primary care, which is usually delivered in smaller institutional settings.

20. These interpersonal benefits are *above and beyond* the benefits to them of their own insurance that they will have if they are required to buy it.

21. Such free-ri der considerations may explain a great deal of the predominant attitude toward insurance in countries such as Germany and the Netherlands, where all non-indigent, low and middle income citizens are expected and required to get insurance. See B. Kirkman-Liff, “Health Insurance Values and Implementation in the Netherlands and the Federal Republic of Germany,” *JAMA* 265, no. 19 (1991): 2496-2502, and F. Heubel, “Patients or Customers: Ethical Limits of Market Economy in Health Care,” *Journal of Medicine and Philosophy* 25, no. 2 (2000): 240-153. A person who needs care but who has not insured carries social and moral disgrace, reflecting not so much paternalistic disdain for those who fail to care for themselves but condemnation for neglecting one’s social responsibilities and free-riding on others.

22. Moreover, in practical terms, a mandate may be very “soft,” exacting as the penalty for non-compliance only a partial contribution viewed as compensation for the costs they impose on others. This, arguably, is the nature of the “mandate” in the 2010 health reform law, *Patient Protection and Affordable Care Act* (2010), U.S.Pub. L. No. 111-148 and supplement, Pub. L. No. 111-152, Health Care and Education Reconciliation Act, *available at* <www.opencongress.org/bill/111-h3590/text> (last visited August 21, 2012) [hereafter referred to as PPACA]. The act’s mandate is certainly soft: no coercion, other than a penalty of $750 added to one’s tax liability. If the Families USA study of 2005 (see Stoll, *supra* note 9) is correct, then the act’s “mandate” does not even recoup the costs that going uninsured shifts to others. Even then, unaccounted for, is a “remainder” of free-riding that occurs through unavoidable receipt of the public-good benefits enumerated several paragraphs previously.


27. Some will think that health care systems cannot, or should not, rely on competitive markets at all for the distribution of insurance. Even if the case for such a position is in the end persuasive, articulating arguments for universal access to basic care that take markets as a serious possibility have the merit of speaking to a wider portion of the political spectrum than arguments that do not.


29. This is precisely the proposal by Goldhill, *supra* note 25.
30. In a single payer or national health service system, basic care’s content must be derived by asking what care, for anyone with the requisite medical need, the society can justify requiring people to pay taxes to fund.


32. See PPACA, supra note 22.

33. This judgment also applies in a single payer or a national health service context. There, too, ignoring effectiveness of care will be exploitation by providers and patients – in this case, of taxpayers rather than premium payers.

34. Examples are many. A prominent procedure is arthroscopic surgery for osteoarthritis of the knee; used relatively frequently, it absorbed nearly $4b of expenditure in 2000; see J. B. Moseley, K. O’Malley, N. J. Petersen, T. J. Menke, B. A. Brody, D. H. Kuykendall, J. C. Hollingsworth, C. M. Ashton, and N. P. Wray, “A Controlled Trial of Arthroscopic Surgery for Osteoarthritis of the Knee,” New England Journal of Medicine 347, no. 2 (2002): 81-88, and G. M. Franklin and B. R. Budenholzer, “Implementing Evidence-Based Health Policy in Washington State,” New England Journal of Medicine 361, no. 18 (2009): 1722-1725. Another apparently ineffective treatment, though at this point only shown to be so in one trial, is Merck’s cholesterol drug Zetia; see N. Singer, “Investors Seem Unshaken After Study of Merck Drug,” New York Times, November 17, 2009, at B3. Interestingly, the study showing Zetia to be ineffective was regarded by investors as good news, since some had feared the study would show it to be harmful. In this case, apparently, only a showing of harm is taken as sufficient reason not to market and use a drug! A showing of ineffectiveness is still reason to market and use it, revealing how low on the effectiveness score the U.S. in practice can sink.

35. An example is CT colonography, which is apparently less cost-effective than colonoscopy for the same conditions. See Franklin and Budenholzer, supra note 34.


38. This is the concern of Jerome Groopman, e.g., as portrayed by D. Leonhardt, “Dr. James Will Make It Better,” New York Times Magazine, November 8, 2009, at 31-37, 44-47.

39. See Franklin and Budenholzer, supra note 34.


