Individual autonomy and state involvement in health care

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Abstract
This article examines the ethical basis for government involvement in health care. It first provides the case for individual autonomy, focusing on the justifications—particularly ethical ones—for allowing individuals to make their own choices in health care, and to control more of their own resources in doing so. Next, it provides the opposite case—for abridging individual autonomy, and in particular, for redistributing resources from those who are well off to those who are not. The overriding reason for favouring the latter case, which trumps the notion of individual autonomy, is to ensure that individuals who are at a disadvantage have an equal probability of attaining good health.

Introduction
For many decades and throughout the world, government has been deeply involved in the organisation, financing, and delivery of health care services. We usually take this strong involvement for granted, and sometimes even equate a country’s health care system with the role taken by its government. This is unfortunate because the foundation and extent of government involvement are predicated on certain key ethical issues. One’s take on the particulars of these issues drive one’s views of when and how much government should intervene in the market-place.

Government has the power to influence any number of aspects of health care strongly. It can, for instance, control the number of providers as well as the kinds of services they deliver; set prices and the types (and even quality) of services that can be provided, particularly when public resources are involved; and have a strong influence on the introduction and diffusion of new products and technologies. One of the most important roles of government is the collecting of taxes, using the revenues to support further regulation of the sector, as well as to finance the distribution of services to those it deems most fit to receive them—most notably the poor, the elderly and veterans.

Having this power and using it ethically are, however, two different issues. What is the ethical basis for government intervention? Are there other strong reasons for government to intervene in the health care market-place? What implications does this have for the role that government does—and should—have in health care? This article considers these issues.

The case for individual autonomy
There are many reasons to believe that individuals should be able to make their own choices in health care. Moreover, there are reasons to think they should have control over (more of) their resources in order to make these choices rather than having them taxed away by government. This section focuses on three major advantages of consumer sovereignty in health care. These advantages are categorised below under the headings of economic efficiency, psychology, and fairness.

Economic efficiency
The central tenet of traditional economic theory is that consumers will be best off if they are allowed to make their own choices about the goods and services they consume. This belief is exemplified by the theory of revealed preference—which posits that allowing people to make their own economic choices will, in and of itself, make them best off. As developed by Paul Samuelson, people are assumed to prefer the bundle of goods that they purchase. If they choose one bundle over another, they have “revealed themselves” to prefer the former bundle. The theory is unusually powerful because it does not require individuals to reflect on their underlying motivations. As Robert Sugden has written: “[The] most significant property of the revealed preference approach . . . is that we do not need to enquire into the reasons why one thing is chosen rather than another. We do not look into the factors that go into the deliberation which leads to a choice; we look only at the results of that process . . .”

The theory of revealed preferences relies on individuals’ abilities to make utility-maximising choices. Going one step further, and assuming that social welfare is simply the sum of all individuals’ welfare, we can conclude that allowing consumers to make their own choices will lead to the highest level of societal welfare. This is the precise argument made by proponents of competition: markets allow people to choose, resulting, in turn, in the best possible outcome for society. In other words, a society where all people make their own choices results in the highest level of satisfaction.

A related reason for encouraging choice is that the use of markets can lead to better value. Choice,
of course, is a characteristic of a competitive market. Having a choice leads to a situation where firms strive to operate efficiently to keep prices low. And to the extent that the goods sold are not homogeneous, competition may also take place on the basis of quality. One should not underestimate the significance of this argument in favour of choice, since better value through lower prices and better quality has the potential to provide overwhelming advantages to consumers.

**PSYCHOLOGY**

The second reason for believing that consumers should have autonomy—in health care as well as throughout the economy—is more psychological in nature: individuals are likely to get more satisfaction out of the goods and services they purchase if they choose them. It is plausible that individuals would prefer the particular goods that they picked out of a set of alternatives, rather than having had these goods assigned to them by someone else. This can be clarified by the following thought experiment. Your employer knows that you need a new car to get to work, knows that you have a certain budget, and picks out for you a particular make, model, and colour, withholding its cost from your pay-check. Compare that to a situation where you pick out your own car. Even if it turns out that you would have picked exactly the same car, the latter situation would satisfy more people because they know it was their choice. When the particular car is assigned by an outside agent, you may be concerned that you might have picked differently if given the choice. Consequently, your satisfaction with the decision will be lower. Some might argue that this would be even more true in health care, where consumer decisions (such as what doctor to see) are very personal, individualistic, and can be of considerable import.

**FAIRNESS**

An argument can be made that it is unfair to tax away an individual’s resources to spend either on other people, or alternatively, on health care resources that the person may not have chosen. Perhaps the main proponent of this philosophy is Robert Nozick, partly in response to John Rawls.

**Rawls’s theory**

Briefly, Rawls’s theory provides an alternative to utilitarian philosophy. In the latter, society’s goal is to maximise collective utility. In contrast, Rawls invokes the notion of fairness to determine how society’s resources are distributed. To determine what is fair, he invokes a concept called the “original position”, in which people choose the principles of a just society from a position where, “no one knows his place in society, his class position or social status, nor does any one know his fortune in the distribution of natural assets and abilities, his intelligence, strength, and the like”. Rawls calls this lack of information about one’s own talents and standing, a “veil of ignorance”. His goal is to determine what system of justice rational, self-oriented people would choose when placed in the original position.

Rawls posits that people in the original position would accept the proposition that primary goods (which he defines as “rights and liberties, powers and opportunities, income and wealth”) “be distributed equally unless an unequal distribution of any, or all, of these values is to everyone’s advantage. Injustice, then, is simply inequalities that are not to the benefit of everyone”.

The upshot is that society is better off only when it makes its least well-off people better off. In other words, society’s resources should be devoted to increasing the primary goods possessed by the most disadvantaged people. The only time that resources will go to the group that does not occupy the bottom rung is when, by so doing, benefits will trickle down to the most disadvantaged group. The overriding implication is that society should engage in far more redistribution than it does currently. This is because resource distribution is quite skewed and, moreover, because much if not most of current redistributive programmes are not targeted solely at those who are worst off in society.

Why would people who are placed in the original position decide on this particular conception of justice? Rawls answers: “Since it is not reasonable for [a person] to expect more than an equal share in the division of social goods, and since it is not rational for him to agree to less, the sensible thing for him to do is to acknowledge as the first principle of justice one requiring an equal distribution. Indeed, this principle is so obvious that we would expect it to occur to anyone immediately.”

Some analysts believe Rawls overlooked a key primary good—access to good health care. According to Ronald Green: “Access to health care is not only a social primary good, but possibly one of the most important such goods [because] disease and ill health interfere with our happiness and undermine our self-confidence and self-respect.”

Although Rawls’s theory is often praised even by those who have criticised it, a number of objections have been raised. One is that people would not choose to redistribute primary goods only to those who are worst off. Another is that, when asked, people seem to choose to maximise average income subject to some minimum floor rather than Rawls’s solution. A third objection is that there is little place in Rawls’s theory for rewarding motivation or hard work, which has ethical implications in itself and raises major issues concerning the efficiency of such a system.

**Nozick’s view of fairness**

A much more fundamental criticism of Rawls, called ”entitlement theory,” has been developed by Robert Nozick. Nozick begins by positing a conception of a just role of government, concluding that this would be a “minimalist state” in which government’s role is limited to such things as mutual protection and enforcement of contracts:
“any state more extensive violates people’s rights”. He concludes that: “The minimalist state treats us as inviolate individuals, who may not be used in certain ways by others as means or tools or instruments or resources; it treats us as persons having individual rights with the dignity this constitutes. Treating us with respect by respecting our rights, it allows us ... to choose our life and to realize our ends and our conception of ourselves, insofar as we can, aided by the voluntary cooperation of other individuals possessing the same dignity. How dare any state or group of individuals do more. Or less.”

There are two main aspects to justice under Nozick’s entitlement theory. The first is the “principle of justice in acquisition of holdings,” which pertains to how a person originally attained a resource, and the second is the “principle of justice in transfer of holdings,” which concerns resources that they subsequently obtain from others. Essentially, what Nozick says is that if a person originally obtained a resource without violating anyone else’s rights, or from another person voluntarily, then he or she is entitled to it.

Unlike Rawls, Nozick believes that people should be able to enjoy the full fruits of any natural advantage they enjoy. If, say, a person is born smart and, as a result, becomes rich, that individual should keep all of his or her wealth as long as the person does not violate anybody else’s rights. Rawls, however, would likely contend that being born smart is a lucky advantage that does not make the person deserving of additional primary resources. Nozick interprets Rawls’s view as saying that “everyone has some entitlement or claim on the totality of natural assets ... with no one having differential claims. The distribution of natural abilities is viewed as a ‘collective asset’.”

At one point in his book, Nozick uses health care as an example. He presents and then refutes an argument made by Bernard Williams, who claimed that societal resources should be redistributed to those in poor health who cannot afford necessary medical care. Nozick counters that Williams “ignores the question of where the things or actions to be allocated and distributed come from. Consequently, he does not consider whether they come already tied to people who have entitlements over them (surely the case for service activities, which are people’s actions), people who therefore may decide for themselves to whom they will give the thing and on what grounds.”

Many objections can be raised about Nozick’s conception of justice. Indirectly, at least, the remainder of this article notes several, in its attempt to justify government involvement in health care. From a philosophical standpoint, the major objection is that people who start at a disadvantage are likely to remain at one. Recall that Nozick says that holdings that were acquired fairly must not be taken involuntarily from an individual. Who is to say what is a fair way of acquiring resources? And how can it be called fair if some people are born in such a disadvantaged position that they effectively have no way to overcome it? Even Nozick admits that he is “as well aware as anyone of how sketchy [his] discussion of the entitlement conception of justice in holdings has been”. A less charitable view is that it is a philosophy espousing the rule of “finders keepers”.

The case for abridging individual autonomy

The case for abridging individual autonomy through government involvement in health care delivery and financing can be based on both fairness and efficiency considerations, each of which is discussed separately, below. More emphasis is given to equity since our concerns here are primarily ethical ones.

FAIRNESS

Why do many philosophers believe that people should not be granted full property rights over the resources they have inherited and/or earned? Rawls states that: “No one deserves his greater natural capacity nor merits a more favorable starting place in society”, and even among economists there are many who agree. Kenneth Arrow, in writing about Rawls’s book, notes that under the theory: “[E]ven natural advantages, superiorities of intelligence or strength, do not in themselves create any claims to greater rewards... Personally, I share fully this value judgment ... But a contradictory position—that an individual is entitled to what he creates—is widely and unreflectively held; when teaching elementary economics, I have had considerable difficulty in persuading the students that this productivity principle is not completely self-evident.”

Why might one believe—in contrast to Nozick as well as students in elementary economics courses—that a person is not fully entitled to the wealth he or she has inherited or accumulated? As a starting point to addressing this question, consider the literature on moral philosophy. Much of it concludes that in a fair society, something must be equalised. A reason is provided by Amartya Sen: “It may be useful to ask why it is that so many altogether different substantive theories of the ethics of social arrangements have the common feature of demanding equality of something—something important. It is, I believe, arguable that to have any kind of plausibility, ethical reasoning on social matters must involve elementary equal consideration for all at some level that is seen as critical. The absence of such equality would make a theory arbitrarily discriminating and hard to defend. A theory must accept—indeed demand—inequality in terms of many variables, but in defending those inequalities it would be hard to duck the need to relate them, ultimately, to equal consideration for all in some adequately substantial way.”

Sen notes that even Nozick’s philosophy does call for the equalisation of something—libertarian rights. Unfortunately, deciding that something ought to be equalised does not tell us what that should be. To consider this, we must first distinguish between two very different but similarly-sounding terms: “equality” and “equity.” The former means equal shares...
of something, but the latter means a “fair” or “just”
distribution—which may not mean equal shares.

The distinction between equality and equity can
be understood by examining the two economic
terms: horizontal equity and vertical equity. Horiz-
onal equity means that two otherwise similar peo-
ple are treated the same with respect to a particular
thing—what we are referring to here as equality. But
vertical equity is much different; it is, according to
Gavin Mooney, “the unequal but equitable treat-
ment of unequals”.

One might, for instance, establish a lower tax rate for the poor than the rich
in the name of equity.

What, then, should be equalised? One line of
thought, advocated by Ronald Dworkin, is that people’s “resources” should be equalised—a philos-
ophy that would appear to be not terribly different
from Rawls’s equalisation of primary goods.

Another, put forward by John Roemer, is that people’s “opportunity” should be equalised. Under
this concept, individuals should be responsible for
their own actions after they are placed on a level
playing-field. Roemer distinguishes between factors
that are under a person’s control and those that are
beyond it. For example, let’s say we want to choose
which people to compensate when they contract
lung cancer so they can pay for their medical care.

The first step is to make a list of factors over which people have little control such as age, ethnicity,
gender and occupation. We then examine the
smoking behaviour of these population groupings.
Suppose that the average 60-year-old, male, black
steelworker smokes for 30 years, and the average
60-year-old, female, white college professor smokes
for eight years. Then, if we are faced by compensa-
tion claims from a steelworker who has contracted
lung cancer who smoked for 20 years, and a profes-
sor who smoked for 15, the steelworker would
receive more compensation—because his behaviour
was more responsible given the circumstances over
which he had little or no control. Stated differently,
had the steelworker had the same opportunity to
become educated about smoking behaviour as the
white college professor, he likely would have
smoked less than her. When we put them on a level
playing-field by comparing their behaviours with
those of others in similar circumstances, the steelworker showed more responsible behaviour
and, if resources are being allocated accordingly,
should receive a bigger share.

A final candidate for equalisation, advocated by
Sen, is the equalisation of capabilities, which
“reflect a person’s freedom to choose between alter-
native lives”. The purpose is to give people
the ability to achieve the things they want. It is
designed to focus not on resources themselves, but
what resources can do for a person.

Equalising capabilities differs from Rawls’s
theory and from equalising resources, in that under
those systems people are given physical resources
but not necessarily the ability to use them for their
own means. It also differs from equality of
opportunity because giving someone the oppor-
tunity does not necessarily mean they will be able to
utilise that opportunity effectively. Equality of
capabilities might mean that more resources would
be given to a disabled person because that person
would need more to reach their goals in life.

Whether one believes in equalising Rawlsian pri-
mary goods, resources, opportunity, capabilities, or
some other construct, there is a common policy
implication: to ensure that individuals who are at a
disadvantage have an equal probability of attaining
good health, it is necessary to redistribute resources from
those who have been more fortunate. This, in a
nutshell, is the ethical argument for government
intervention in the health care market.

EFFICIENCY

The focus up till now has been on ethical
considerations. Here we briefly mention the other
reason that government might intervene in the
market—to improve economic efficiency. Indeed,
many if not most of the reasons that government
intervenes in health care have nothing to do with
fairness, but rather with economic efficiency.

There are a number of “classic reasons” for gov-
ernment intervention in health care. Some goods
and services might be public goods, where the good
or service in question can be consumed by numer-
ous people at once without detracting from each
other’s enjoyment of it, and where it is difficult to
exclude people from using it, even if they do not
pay. (An example in health care might be television
announcements providing the public with useful
medical information.) Not surprisingly, these are
typically underproduced by competitive markets.

Other goods have “externalities” associated with
them. When there are positive externalities, a
person’s or firm’s actions have benefits that accrue
to those who are not involved in the transaction (for
example, immunisations benefit others). In the case
of negative externalities, transactions have a nega-
tive effect on others (for example, smoking). A free
market tends to underproduce goods and services
that have positive externalities, and overproduces
those with negative externalities. Government
intervention of some sort may rectify the situation,
and may be the least costly way of doing so.

A third example are goods that are characterised
by “increasing returns to scale”—basically, when
average costs decline as the scale of production
increases. This usually occurs when a very large
capital investment is necessary and it is uneconomi-
cal for more than one firm to be in a particular
market. State-of-the-art teaching hospitals are
sometimes thought of as such an example; without
government subsidies they might never be profit-
able.

The above examples are typical justifications for
government intervention in many markets, not just
health care. But health care has its own peculiari-
ties, which also may necessitate government
involvement to improve efficiency. I have written a
book on these issues and will not repeat them
here. Some examples include:

- Having the government provide objective infor-
mation about health plan, hospital or physician
quality because consumers would find it difficult to make a utility-maximising choice without it; markets tend to underproduce public goods such as information.

- Controlling the diffusion of medical technologies because they are being overused, thus raising health care cost with little to show in the way of marginal benefits.
- Regulating the enrolment practices of insurers, who otherwise might avoid particular patients or small employers who have a history of illness. This is not just an issue of equity; insurance markets are inefficient if they are not available to a segment of the population who desire coverage or services to those who would otherwise not be able to afford them.

When using efficiency criteria to justify government intervention, it is necessary to understand that governmental actions will help some individuals and firms and hurt others. Put differently, government actions will nearly always be viewed as unfair by some. Ideally, one would hope that government would act when there will be an overall improvement in the workings of society or the economy. One might also hope that providing health care coverage or services to those who would otherwise be unable to afford them would benefit those who get satisfaction from knowing they live in a more compassionate society (which an economist would refer to as a “positive externality of consumption”). But whether these things are sufficient to make up for the losses suffered by some is an ethical issue that must always be faced.

**Conclusion**

A number of reasons—economic, psychological, and ethical—can be given for granting individuals autonomy over the choices they make in health care. Moreover, similar arguments can be made for people to have more control over their economic resources rather than taxing them away by government. There are, nevertheless, even more compelling reasons for government to become actively involved in health care. This article focused on ethical reasons, although there are efficiency reasons for doing so as well. The main ethical reason for government involvement is that individuals should not be penalised—through poorer access to health care services and/or poorer health—because of economic or social circumstances which are beyond their control. Redistributing resources is necessary if they are to have the same opportunity to enjoy good health as others.

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**References**

5. See reference 4: 12.
7. See reference 4: 150-1.
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