PAPER

Dworkin's prudent insurance ideal: two revisions

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ABSTRACT

This article offers two revisions to Dworkin's 'prudent insurance ideal', which aims to account for justice in the distribution of healthcare so that (a) it can deal with market failures in healthcare and (b) when applied to unjust societies it addresses health problems caused by injustice in a fair manner.

INTRODUCTION

In chapter 8 of his book *Sovereign Virtue* titled 'Justice and the High Cost of Health', Ronald Dworkin offers an appealing answer to the questions of how resources should be allocated between health and other social needs and how healthcare resources should be allocated among different patients.[1] His answer relies on a hypothetical insurance scheme, which he calls *the prudent insurance ideal*.

Dworkin's prudent insurance ideal aims to correct the shortcomings of a free market in healthcare by incorporating the following modifications. First, 'the distribution of wealth and income is as fair as it possibly can be' (Dworkin, p 311).[1] Second, everyone has 'state-of-the-art knowledge about the value and cost and side effects of particular medical procedures' (Dworkin, p 312).[1] Third, 'no one—including insurance companies—has any information available about how likely any particular person is to contract any particular disease or to suffer any particular accident' (Dworkin, p 312).[1] Suppose that people, under these conditions, make decisions about how much to spend on healthcare and what kind of healthcare to purchase; Dworkin claims that 'whatever that transformed community actually spends on health care in the aggregate is the morally appropriate amount for it to spend' and 'however health care is distributed in that society is just for that society' (Dworkin, pp 312–3).[1] Dworkin also suggests that his prudent insurance ideal can offer guidance to imperfect societies on the distribution of healthcare. By imagining the decisions that most people would make in Dworkin's transformed society we can arrive at 'guidelines for what justice requires now' in imperfect societies (Dworkin, p 313).[1]

This paper identifies two problems with Dworkin's account and proposes revisions to deal with these problems.

THE FIRST REVISION

Dworkin's prudent insurance ideal takes the market mechanism for allocating healthcare as its basis and corrects some of its shortcomings. However, his proposal does not go far enough. It neglects market failures due to negative externalities and the fact that many determinants of health are public goods. In this section, I will first present some of these market failures and then offer a revision of Dworkin's theory that helps it address these problems.

One source of market failures in healthcare is the fact that many determinants of health are public goods. Public goods have two characteristics: non-excludability and non-rivalry. A good is non-excludable if it is impossible or very costly to exclude other people from consuming it when the good is provided for one person. A good is non-rival when the consumption of one person does not decrease the amount of the good available for another. Streetlights are a common example. When a street is lit, it is difficult to stop someone walking on the street from benefiting from it—it is non-excludable—and one person's consumption of the light provided by the streetlight does not diminish the benefit others get from it—it is non-rival.

The free-rider problem causes markets to undersupply public goods. Suppose that each actor (rightly) believes that whether they contribute or not will not affect the provision of the public good, and they know that the good is non-excludable. Under these circumstances, they have no incentive to contribute to the public good's provision because once the good is provided they will also be able to benefit from it without having contributed, and their individual actions do not affect the good's provision. In other words, they can free ride. Since this reasoning applies to all individuals, the public good will be undersupplied even though everyone would benefit from its provision. Many determinants of health are public goods and will be undersupplied by the market. Here are some examples.

When a sufficiently large portion of the population has been vaccinated for a given disease, the probability that someone who has not been vaccinated will get the disease also falls. This phenomenon, known as *herd immunity*, is a public good. If individuals can benefit from herd immunity without incurring the costs and risks of vaccination, they will choose not to be vaccinated. As a result, the vaccination rate will be less than the socially optimal rate.[2]

The monitoring of infectious diseases is also a public good. Bodies monitoring the spread of infectious diseases enable us to take measures that can control the disease at its source. Such bodies have obvious benefits. However, would they be set up and maintained by the market mechanism? Consider the choice each agent faces. If such a body

exists, everyone in the area monitored will benefit. However, whether or not such a body exists does not depend on any given individual's actions. Therefore, even though everyone would prefer having such bodies in place, no one would have the incentive to contribute to setting up and maintaining such bodies. Similar points apply to the funding of public campaigns that will encourage healthy lifestyles or promote organ donation in societies where there are no markets for organs, and the funding of basic research in biology that will contribute to medical research. All of these are public goods that contribute significantly to health but would be undersupplied in societies relying solely on the market.

Another source of market failures in health are negative externalities. A negative externality occurs when individuals do not pay for the full costs of their decisions and pass on some of these costs to society. Antimicrobial resistance, where microorganisms become resistant to antimicrobial medicine, is one negative externality. One cause of antimicrobial resistance is the use of antimicrobial medicine. Setting aside several details, the crux of the problem is that even though the use of antimicrobial medicine benefits the individual, the antimicrobial resistance caused by its use harms society as a whole. To overcome this problem, we need non-market mechanisms, such as regulations limiting the use of antimicrobial medicine.[3] These mechanisms cannot be created by individuals considering which treatments and insurance policies would be prudential for them to purchase. Rather, they have to act as a limit on the insurance policies and treatments on offer.

I have argued that many measures that contribute to individuals' health are public goods and there are negative externalities in healthcare. Economic theory predicts market failures under these conditions. Since Dworkin's scheme relies solely on the market mechanism, it needs to be revised so that it can avoid market failures. Before introducing my revision to Dworkin's proposal I would like to address two objections maintaining that a revision is not called for.

It has been noted by commentators on Dworkin's proposal, such as Norman Daniels, that Dworkin 'focuses primarily on personal medical services and not broader public health measures that reduce overall risk or distribute that risk more fairly' and that he does not address 'interventions beyond individual treatment or prevention measures' (Daniels, p 29).[4] Therefore, the problems I have raised are outside the purview of Dworkin's theory. This objection applies only to some of the examples I have presented. Dworkin takes his account to apply to preventive medicine (Dworkin, p 315).[1] Accordingly, the public good of herd immunity and the issues it raises fall under this scheme. Since individual healthcare falls under Dworkin's theory, the negative externality problem due to antimicrobial use is also relevant to Dworkin's theory. Furthermore, if Dworkin's theory can be extended to cover public health measures without departing from its central tenets this is a welcome improvement on the theory.

A second objection maintains that the issues I have raised relate to efficiency and not to justice, and Dworkin's theory is only concerned with the latter. This claim about Dworkin's theory is hard to sustain given that one of Dworkin's key objections to the existing healthcare system in the USA is that 'collective [health] expenditures are too high' under it (Dworkin, p 311).[1] Even if we suppose that this objection is sustained, there are justice-related reasons to be concerned with public goods and negative externalities. Someone who benefits from herd immunity without contributing is taking unfair advantage of others. A similar point applies to people whose use of antimicrobial medicine contributes to antimicrobial resistance. They are causing harms to others without contributing to the amelioration of these harms. Dworkin, in fact, recognises the threat to justice posed by externalities. His theory of justice aims to ensure 'a distribution of resources equal in opportunity costs' (Dworkin, p 156).[1] Dworkin notes that the market cannot bring about this goal when there are externalities, and introduces measures to address them (Dworkin, pp 155–8).[1] In light of this, we can safely conclude that we are including concerns that Dworkin, elsewhere in his theory, recognises as legitimate.

We can revise Dworkin's proposal to handle both the problems I have raised by making the agents in his scheme consider and jointly choose from different packages containing public goods, which contribute to health, and policies governing individuals' health choices that address negative externalities. These packages, which the hypothetical agents consider, will differ in the amount of resources they allocate to immunisation for different diseases and the amount of resources they allocate to public information campaigns and other means aimed at decreasing the likelihood of different diseases. They will also contain different policies dealing with negative externalities in healthcare such as measures governing the use of antimicrobial medicine. We assume that (a) the agents considering these packages are informed about how different packages alter the likelihood of different diseases and how much their provision costs and (b) they know that the package that most people choose will be adopted by the society as a whole, and everyone will be required to contribute equally to its provision. Armed with this knowledge, hypothetical agents can rank and choose from different packages. The package of public goods and policies that most agents pick is the one that is appropriate for a just society.

A few explanatory comments about this proposal are in order. It is the assumption that everyone contributes the same amount that enables us to overcome the free-rider problem. The free-rider problem arises because agents can benefit from public goods without contributing to their provision. By introducing a non-market mechanism that ensures that everyone contributes to the provision of the package that most agents pick we avoid the free-rider problem. The introduction of health policies that bind all individuals addresses the problem of negative externalities. The nature of the policies will depend on the negative externalities in question. It will be the hypothetical agents, who we assume are well informed, that determine which specific policies to adopt.

We have to concede that this revision, to some extent, betrays the spirit of Dworkin's proposal. In Dworkin's scheme the healthcare each individual is allocated reflects the value they set on health and other goods. This is a significant part of its appeal. As Dworkin puts it, his proposal 'respects the personal judgements of need and value that citizens have actually made, or would be likely to make under appropriate conditions' (Dworkin, p 319).[1] If one person cares less about health than other goods, then he or she can choose to buy less insurance. If someone cares deeply about how they fare in the last months of their lives they can buy insurance that covers that period better than others. The packages that the agents choose are not like this. Only one package of public goods and policies can be implemented. The package that we implement and fund will reflect only one set of valuations of health and other goods. Accordingly, it can no longer be claimed that the healthcare that any given individual receives is solely a reflection of the value they set on health and other goods. The public measures that

contribute to health are what the majority of well-informed agents would choose.

Even though this revised version of Dworkin's proposal will not have all the appealing features of Dworkin's theory, it still retains much of its appeal. Most of the *private* healthcare goods that different individuals receive will still be ones that they have chosen and will reflect the value they set on these goods. There is also evidence from the rest of Dworkin's theory suggesting that Dworkin would not be hostile to the proposed revisions. When he takes the predicted results of the prudent insurance scheme in a perfect society and applies it to imperfect societies, Dworkin does not require making predictions about what would be prudent for each individual. Rather, he looks at what would be prudent for most people to buy for themselves (Dworkin, p 313).[1] Therefore, we can conclude that this proposal is a compromise that Dworkin would and *should* be willing to make. Even though the set of public measures adopted will not reflect the value each individual sets on health and other goods, it will reflect the valuations of the majority and will definitely be an improvement over schemes that do not correct for market failures.

THE SECOND REVISION

The second problem that requires a revision of Dworkin's proposal concerns its application to imperfect societies. According to Dworkin, we can answer questions about justice in the distribution of healthcare in our societies by looking at the results of the prudent insurance test:

> [T]he prudent insurance test helps to answer both questions of justice…: How much should America spend overall on its health care, and how should that health care be distributed among its citizens? The test asks what people would decide to spend on their own medical care, as individuals, if they were buying insurance under fair free-market conditions, and it insists, first, that we as a nation should spend what individuals would spend, collectively, under those conditions; and, second, that we should use that aggregate expenditure to make sure that all have now, as individuals, what they would have then (Dworkin, p 317).[1]

In this proposal, we look at the patterns of healthcare spending in a just society and apply it to unjust societies. This proposal makes sense only on the assumption that individuals face the same health risks in both societies. This assumption is false. In this section, I will first outline the nature of this problem and present a revision that helps Dworkin's proposal avoid it.

Economic inequalities are translated into health inequalities. The economic means at one's disposal determine, to a large extent, one's lifestyle, which in turn determines one's health and the risk of getting different diseases. For instance, those who are poorer are more likely to eat less healthy diets than those who are richer.[5] This will make them more likely to get various diseases caused by a bad diet. We can reasonably predict that in a just society, diseases caused by lack of access to a healthy diet will be rarer than they are in unjust societies. People buying health insurance under the conditions Dworkin imagines will buy less insurance for these diseases that are less common in just societies. If we take the policies in Dworkin's just society as our guidelines, our societies will also have less coverage for these diseases. This will cause the worse off to suffer a further injustice. They will not only suffer the injustice that condemns them to material deprivation, which harms their health, but they will also suffer from a lack of coverage for the diseases that they get due to the material deprivation they suffer from. To sum up, the probability that a given person in a just society gets a particular disease is different from the probability that a given person in an unjust society gets the same disease. Accordingly, just and unjust societies should offer different amounts of coverage for the same disease.

There is also reason to believe that the *total* amount spent on healthcare in just and unjust societies should differ. Epidemiologists such as Michael Marmot and Richard Wilkinson have argued that inequalities of power, status or resources have detrimental effects on the health of those lower in the social ladder.[6 7] This claim differs from the one introduced in the previous paragraph which was that those who are worse off have fewer material resources and the material deprivation they suffer from harms their health. Marmot and Wilkinson argue that inequality *itself* harms the health of those worse off. If this is correct, the unjust society will have an additional cause of bad health that does not exist in the just society. Accordingly, the absolute amount that a just society and an unjust society need to spend on healthcare to attain the same health outcomes will be different.

The health of a society and the distribution and likelihood of different diseases in that society are not independent of the level of economic justice in that society. Consequently, even if we assume that Dworkin gives us a correct account of justice in healthcare for a just society, using the health policies in a perfectly just society as guidelines for our imperfect societies would be unfair to those who suffer injustice and fail to bring about the same level of health.

Fortunately, this problem can be handled by making a slight revision to Dworkin's account. When employing the prudent insurance ideal to determine the just distribution of healthcare for our societies, we need to ask what healthcare and insurance well-informed individuals with their fair shares of resources would buy if they knew the probabilities for getting various diseases in *our* societies. When we make this simple revision, the policies that we formulate in light of the prudent insurance ideal will be sensitive to the health problems that exist in our societies. The health problems that the worse off are prone to suffer from will be allocated more resources than they would otherwise be allocated.

There is one legitimate worry about health in unjust societies that this revision leaves unaddressed. It is unfair that some people are likely to be less healthy than others through no fault or choice of their own. The application of the revised version of Dworkin's proposal does not address this. However, this unfairness can only be effectively dealt with by addressing the injustices that bring about these unfair health outcomes. The revised version of Dworkin's proposal only ensures that when the worse off get ill they will receive the healthcare that they are due.

CONCLUSION

In this paper, I have identified two problems with Dworkin's account of justice in the distribution of healthcare and offered two revisions to help deal with them. The first problem and revision concerned Dworkin's account of justice in the distribution of healthcare in just societies where people have access to a fair share of resources. According to Dworkin, the results of individual choices in a free market in healthcare would be just provided that everyone has their fair share of resources, are well informed about medicine and no one knows how likely any given individual is to contract any particular disease. I have argued that since many determinants of health are public goods and there are negative externalities in healthcare, there would be market failures in societies implementing Dworkin's proposal.

Dworkin's prudent insurance ideal can address this problem by incorporating a module in which the hypothetical agents choose a package—containing public goods that contribute to health and policies for dealing with negative externalities that binds them all—to which they all contribute equally. The second problem and revision concerned the move from what justice in the distribution of healthcare in a just society would look like to what justice demands in imperfect societies. Given that the health problems and their distribution in societies are not independent of the overall justice of a society, we should not look at the insurance Dworkin's hypothetical agents would purchase given the likelihood of getting particular diseases in just societies. Instead, we should look at the insurance and healthcare these agents would buy given the distribution of health problems in our societies.

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