

Medical Egalitarianism and Patients' Prior Consent

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Abstract

It has been argued that medical egalitarianism, i.e. the principle of equal health care for equal medical needs, can not be justified, since poor patients would prefer *less* health care and *more* consumption of other commodities. However, the relevance of this argument must be questioned. Even if all poor persons, *isolated*, would prefer to shift part of their health care to other consumption, all poor persons could prefer medical egalitarianism above the alternative that would be the outcome if *all* poor persons made such shifts. A person's preference in the *isolated* choice of the person's own consumption could differ from the person's preference in the *social* choice between different health care allocations, since there are important externalities of health care consumption, and since a person could have preferences for other persons' health care, even if the person's own consumption is not influenced.

1 Introduction

In assessments of different allocations of medical care, Menzel (1990) proposes a so called *prior consent* model. A certain allocation of health care is better than another if it could have been, or preferably *has been*, chosen by prior consent of the patients:

... if individual patients beforehand would have granted consent to the rationing policies and procedures in question (or more clearly yet, if they actually have consented to them), then the appeal of those policies and procedures will rest not merely on attachment to the morally controversial goal of overall aggregate welfare, "efficiency"; such policies will gain their moral force from respecting individual patients' own will (p. 10).

What it is right for us to do to others is determined more fundamentally by people's consent than by whether we adequately compensate them. Both actual compensation and the economist's surrogate for efficiency, potential compensation, gain what moral permission-creating power they might have from the hypothetical prior consent they can sometimes elicit (p. 27).

Neither *actual* compensation nor *potential* compensation is convincing in an argument for a certain health care policy. It is certainly more convincing to argue that the persons involved have granted consent to the policy, at least if the persons were well-informed and did not make any mistakes. On this normative

basis, Menzel argues that medical egalitarianism - i.e. the principle of equal health care for equal medical needs - can not be justified, since the patients would prefer an alternative health care allocation.¹ In this article I will argue against this conclusion.

2 The concept of preference

Since my discussion will refer to economic analysis, it is important to make some comments on the concept of preference, which is of fundamental importance in economic analysis. In the economic literature, this concept is commonly used in two different meanings. First, a person's preference for x above y means that the person's *welfare* is greater in x than in y . Second, it means that the person would choose x in a *choice* between x and y . One reason why a clear distinction between these two definitions commonly is not made is probably that it is often assumed that a person's behaviour is rational in the sense that the person would always choose the alternative which maximises the person's own welfare. The traffic between these two interpretations goes in both directions. A person's welfare is inferred from the person's *actual* choices, and a person's *hypothetical* choices are inferred from assessments of the person's welfare.

Economists sometimes refer to a special definition of "non-paternalism", according to which a person has a sovereignty over how his welfare is to be

¹ The term "medical egalitarianism" was coined by Graham (1987, p. 53).

measured, and the person's choice reflects the person's own welfare.² I would argue that the question if the person's choice reflects the person's own welfare is an *empirical* question, which cannot be resolved by such definitions.

Furthermore, if these preferences differ, non-paternalism, more properly defined, seems to require that the person's *choice* preferences are given priority, but certainly not that these are doctored to represent the person's *welfare* preferences. Sen (1991) has argued for such a "'twist' in the characterization of the informational foundation of social welfare judgements":

By seeing individual preference as intrinsically important and individual welfare only derivatively so, the empirical studies have to concentrate on choice as such (p. 20).

One objection against such an approach would be that a person's actual choices could be based on insufficient, or even incorrect, information. Such choices will be an insufficient basis in a normative analysis:

² See, for example, Boadway and Bruce (1984, p. 8), who make this definition explicit: "One further important value judgment required is that the welfare of the household must either correspond with the household's own view of its welfare, or at least be consistent with the household's preferences. The assumption that social welfare must respect household preferences is called *non-paternalism*. This assumption is rather important for many of the results of theoretical and applied welfare economics, since household preference orderings are reflected in the choices the household makes when faced with alternative situations. We can therefore deduce information concerning the household's preference orderings on the basis of choices actually taken". See also, *ibid.*, pp. 39-40.

... attention has to be paid to the possibility that ignorance, hastiness, or for that matter, strategic considerations, may distort actual choices vis-a-vis what would be chosen with informed reflection without strategic deflections (p. 20).

It must, however, be noted that this is a problem also for the conventional economic analysis. In this, however, the corrections of observed choice are guided by the *welfare* preferences. Sen argues that the corrections must be "*neutral* between the different *motivations* that can influence choice". He explicitly points out that "there will be no ground for a 'welfarist' bias in interpreting and doctoring observed choices in the direction of individual welfare" (p. 20).³

Such an approach seems essential for a normative model, based on prior consent. Other concerns than about one's own welfare have to be considered. In a welfarist assessment such concerns are irrelevant. However, if persons' choices actually are motivated by such other concerns, these must be considered in a normative analysis based on persons' prior consent .

³ "Welfarism" is one foundational element in the utilitarian moral approach; states of affairs are judged entirely in terms of personal utility information relating to the respective states. In economic analysis, welfarism is commonly presumed, explicitly or implicitly. The term was coined by Sen (1977b/1997a).

3 Compensation

Menzel is, as witnessed by the quotation in the introduction, explicitly critical to arguments based on actual and potential compensation. However, in some reasonings he seems to accept actual compensation. He refers to a factory, which ... saves so much money by not installing pollution control equipment that it could then compensate neighboring homeowners who are adversely affected more than what clean air is worth to them, and still be better off itself (Menzel, 1990, p. 25).

Menzel claims that if "the homeowners are the only ones affected, polluting rather than controlling is here *the efficient, welfare-maximizing course of action*."⁴ He maintains, however, that this is not a convincing argument against installing pollution control equipment:

⁴ Ibid. (italics are mine). He also claims that the "factory's behavior increases overall utility" (ibid.). However, these claims are not warranted. See, for example, Arrow (1951/1963, pp. 44-45), Baumol (1977, p. 530) and Sen (1979/1984, pp. 423-425). The fact that the factory owners *could* compensate the homeowners, and still be better off themselves, does not exclude that polluting will provide less aggregated welfare than installing pollution control equipment, if compensation is *not* made. Aggregated welfare will in many cases *decrease* by a project that is a potential Pareto improvement, i.e. a project that could be financed so that all are better off. It is true that it would have increased, *if* the homeowners were compensated, but that is not relevant, since they are not. It must be noted that Menzel subsequently makes the following comment: "Poor Peter's willingness to pay less than Rich Robert may still leave Peter getting greater utility out of a thing he is paying for than Robert would get" (Menzel, 1990, p. 35n. 9). I agree, but then polluting is not necessarily the welfare-maximizing alternative.

Since the compensation to them is only potential, however, and not actually paid, few would put much moral stock in the bare fact that failing to install pollution control equipment was efficient. Unless the losing homeowners actually get compensated, no one is impressed (p. 25).

However, Menzel's argument is only that the compensation is not actually made, and not that it is based on *welfare* preferences rather than *choice* preferences. In the above quotation, and also in the following, Menzel seems to accept polluting if the losers are compensated for their welfare losses, even *without* their consent:

Thus, if preexisting moral rights are present, merely potential Pareto superiority (efficiency) controls little by itself. Either actual compensation *or* some sort of consent is required. This holds for efficiency in medicine as well as for efficiency anywhere else. It is thus clearly understandable how, in the individually urgent and injustice-of-illness context of common medical situations, we are inclined to demand some sort of actual compensation *or* consent before we give efficiency much weight (pp. 25-26. Italics are mine).

However, even if the homeowners would be compensated so that nobody is *worse off* by the polluting, they would not necessarily *consent* to the polluting. Likewise, even if a patient is compensated for not having a certain treatment, she would not necessarily consent. It must, however, be noted that Menzel in the subsequent discussion, as witnessed by the quotation in the introduction, explicitly maintains that actual compensation is not a morally acceptable alternative to consent.

A normative problem with both actual and potential compensation in a prior consent model is that they are based on *welfare*.⁵ Furthermore, the relevance of *potential* compensation as a measure of welfare can be questioned, since the compensation is not *actually* paid. This means that a potential Pareto improvement could *decrease* aggregated individual welfare, while a move that is not a potential Pareto improvement could *increase* aggregated individual welfare. A potential Pareto improvement could even conflict with the Pareto principle, i.e. a move from y to x could be a potential Pareto improvement, *even if all persons are better off in y than in x* .⁶

4 Medical egalitarianism and prior consent

Menzel's main argument against medical egalitarianism is that a rational poor person would prefer to decrease her health care consumption, if an equivalent increase of *other* commodities can be made:

If one is poor one will certainly prefer to spend less on preserving health and saving life than if one is well off ... (Menzel, 1990, p. 116).

⁵ Of course, a person's compensating variation or equivalent variation can be defined in terms of *choice* preferences. As noted previously, however, it is commonly interpreted in terms of *welfare* preferences. This is also Menzel's interpretation.

⁶ See Arrow (1951/1963, pp. 44-45). Arrow notes that "[t]his suggests strongly that unaccomplished redistributions are irrelevant" (p. 45). This conflict also means that a potential Pareto improvement could *decrease* efficiency, according to the most fundamental efficiency criterion in economic theory, viz. the Pareto principle.

Menzel's "rational poor person model" is difficult to apply in practice, which Menzel also admits, since "we are not sure how rational poor people would actually choose" (p. 127). He notes that it is also "fundamentally indeterminate" since it lacks a "conception of the fair share with which poor people have to work in making their choices" (p. 127). He argues, however, that "it can still constitute an important allocative check on how much of whatever is provided the poor should finally be in the form of health care":

Take any given share of resources made accessible to the poor (their own resources, together with whatever public supplement). If rational poor people would be likely to shift funds from what is provided in medical benefits to something else, then too much is being offered as medical benefits. Thus, even if assistance is provided in kind and not in cash, reference to the choices of rational poor people will be an important conceptual device in retaining a welfare state's respect for recipients' freedom (pp. 127-128).

It seems reasonable that a poor person in a system, based on medical egalitarianism, in which all persons are entitled to the same comprehensive health care insurance, would make a net welfare gain by decreasing her health care consumption and make an equivalent increase of her consumption of other commodities. Marginal utility of the decreased consumption of health care would typically be smaller than marginal utility of the increased consumption of other commodities.

However, I will argue that this does not necessarily mean that "too much is being offered as medical benefits", not even if "too much" is defined as the

difference between the actual consumption and the consumption that would have granted consent of rational poor persons. Menzel's main argument against medical egalitarianism is that *all* poor persons would have granted consent to a reduction of the health care consumption they are entitled to in such a system, if they can spend an amount equal to the cost of the decreased health care consumption on *other* commodities. However, this argument is not convincing, since it is based on what a rational poor person would choose *isolated*. As I will try to show, even if a poor person, *isolated*, would make a net welfare gain by decreasing her consumption of health care, her welfare would not necessarily increase if *all* poor persons decreased their consumption of health care.

Let's apply the framework of "social choice theory" in an examination of Menzel's argument against medical egalitarianism. The argument implies two social states, viz. **A**, the actual state with medical egalitarianism, and **B_i**, the state that would be the outcome if a poor person *i*, *isolated*, would choose a less comprehensive health insurance and increase her consumption of other commodities than health care by an amount equivalent to the cost of the decreased health care consumption.

Let's define **C** as the social state that would be the outcome if *all* poor persons changed their consumption according to their preferences between **A** and **B_i**.

Menzel claims that for each poor person *i*, the person is better off in **B_i** than in **A**. As noted above, I don't dispute *that*. However, **B_i** and **A** are *not* the relevant alternatives to determine if the poor person would be better off by a policy, in which *all* poor persons could decrease their consumption of health care, and

make an equivalent increase of their other consumption. The relevant alternatives must be **C** and **A**.

It can be argued that the social choice between **A** and **C** should *not* depend on individual preferences for *other* alternatives, for example **B_i**. Such other alternatives are *irrelevant*. This condition, "independence of irrelevant alternatives", is one of the conditions in Arrow's classic General Possibility Theorem (Arrow 1951/1963), more often called Arrow's Impossibility Theorem. As Arrow formulated this condition, it entails two different aspects, viz. the "irrelevance aspect" and the "ordering aspect".⁷ The former excludes all information on "irrelevant" alternatives, and the latter excludes all information *other* than preference orderings. A serious problem with Menzel's argument against medical egalitarianism is that it conflicts with the "irrelevance aspect" of the condition of "independence of irrelevant alternatives", since it depends on preferences for the irrelevant **B_i**.

Would a poor person be better off in **C** than in **A**, if she is better off in **B_i** than in **A**? No, not necessarily. There are at least two reasons why her welfare could be *lower* in **C** than in **A**. First, there are externalities of health care consumption, i.e. a person's consumption is influenced by *other* persons' consumption of health care. Externalities of health care consumption are quite significant. The treatment of infectious diseases is a classic example, but the most important externalities originate from the fact that health care consumption influences health, which, in turn, influences a person's contribution to the formal, and the informal, economy. Second, even if a person's *consumption* is not influenced by

⁷ This is noted by Sen (1970, pp. 89-92).

other persons' health care consumption, his *welfare* could, by "sympathy", be influenced.⁸

The existence of externalities and "sympathy" means that there is another weakness in Menzel's critique of medical egalitarianism. Menzel mainly discusses the prior consent of *the poor*. This may seem reasonable, since only poor persons would decrease their health care consumption.⁹ However, since there are externalities of health care consumption, and since people, by "sympathy", could be influenced by other persons' health care consumption, the welfare also of non-poor persons would be influenced by the move from **A** to **C**. It seems reasonable to assume that the welfare of non-poor persons would

⁸ Sen (1977a/1997a) makes a distinction between "sympathy" and "commitment".

The former corresponds to cases "in which the concern for others directly affects one's own welfare". Concerns for others could also be motivated by commitment, in which case it has nothing to do with the effect on one's own welfare: "If the knowledge of torture of others makes you sick, it is a case of sympathy; if it does not make you feel personally worse off, but you think it is wrong and you are ready to do something to stop it, it is a case of commitment" (pp. 91-92).

⁹ Health care demand is, of course, not only influenced by income. It is, however, an important factor, and, to simplify, I have defined "poor" people as people who would prefer to shift parts of their consumption of health care in **A** to other consumption. It could be argued that, analogously, "rich" people would prefer to *increase* their health care consumption from the level in **A**. It is quite reasonable that rich people would prefer a *more* comprehensive health insurance than the tax financed in **A**. An important difference, however, is that in actual systems based on medical egalitarianism, there are no restrictions for a person to complement his tax financed health care with privately financed. Hence, rich people will consume *more* health care than other people, even in systems based on medical egalitarianism.

decrease, which could be a motive also for non-poor persons *not* to consent to a move from **A** to **C**.

Menzel's critique against medical egalitarianism could be interpreted as based on a principle of *consumer sovereignty*; every person has a *right* to consume whatever he wants within a given budget. Part of this given budget is the actual costs of the health care consumption in **A**. If a person wants to use some of these resources in *other* ways than in the consumption of health care he should be free to do that, no matter what other persons think.

There are at least two main problems with this principle. First, since there are externalities of health care consumption, the meaning of a "given budget" is not straightforward. *Other* persons' consumption will be influenced by the decrease of person's health care consumption. It can even be demonstrated that this principle could conflict with the *unanimity principle*, i.e. that a certain alternative should not be chosen if there is another alternative that all persons would rather choose. I have already shown that all persons could be better off in **A** than in **C**. Suppose that is the case, and that all persons are rational in the conventional economic sense. That means that they would all choose **A** in a choice between **A** and **C**:

According to the *unanimity principle*, **C** cannot be chosen.

Every poor person would want to shift her consumption of health care in **A** to other commodities:¹⁰

¹⁰ As previously shown, this assumption does not necessarily mean that the persons would choose **C** in a choice between **A** and **C**. What is assumed in this example is that

According to the *consumer sovereignty principle*, **A** cannot be chosen.

Hence, neither **A** nor **C** can be chosen, and in the social choice between **A** and **C** these two principles conflict. This conflict is, of course, a problem for a supporter of both the prior consent model and the consumer sovereignty principle. Its normative relevance is that we sometimes have to choose between these principles. In the social choice between **A** and **C** in this example, the *unanimity principle* seems more reasonable than the *consumer sovereignty principle*. If the persons *themselves* do not respect their preferences for \mathbf{B}_i against **A**, why should these preferences be respected? To accept the *consumer sovereignty principle* in the example above, in which all persons are rational in the conventional economic sense, would mean a move from **A** to **C**, if the initial state is **A**. Since all are better off in **A** than in **C** - otherwise they would not have chosen **A** in a choice between **A** and **C** - this means that *all* persons would fail to achieve exactly what they are trying to achieve in their isolated choices, i.e. to increase their own welfare.

A second problem with the *consumer sovereignty principle* is the implementation of **C**. Both **A** and **C** are tax financed, and, hence, depend on political support, not only from poor people, but also from non-poor people. This means that **C** might not even be possible to implement. There are also other problems with implementing **C**. The administrative costs would probably be quite substantial. For each person who wants a less comprehensive health

every poor person i would choose \mathbf{B}_i in a choice between \mathbf{B}_i and **A**, and that *all* persons would choose **A** in a choice between **A** and **C**.

insurance, an equivalent amount of money must be determined.¹¹ Sen (1973/1997b, p. 79) notes that this also means greater risks of abuse:

... it is pertinent to note that the provision of cash subsidies opens up greater possibilities of abuse through pretensions of greater needs, thereby bedevilling the problem of decidability. When medical services are provided in kind, the link-up with needs is more direct and the practical problem of identifying needs is to that extent reduced.¹²

Furthermore, the health care system must provide different treatment alternatives for a given medical need, depending on how comprehensive the patient's health insurance is. Menzel (1990, p. 128) comments on this problem:

The practical point that providers find it too difficult to shift between different conceptions of adequate care does not justify seeing equal care for equal medical needs as ideal, nor does it realistically help when we get to policy decisions about reimbursement for discrete, separable items of care.

However, even if this difficulty, *on its own*, can not justify medical egalitarianism, it cannot be dismissed. Can we abstract from these problems and suppose they do not exist? That would bring us into another "irrelevant"

¹¹ It can be argued that the implementation of *C* could be based on transfers in *kind*, and not in *cash*. In the end of section 5, I will show that the problems discussed here, and in section 5, will be just as serious, no matter if transfers in *C* are made in cash or in kind.

¹² See also Sen (1999, pp. 133-135).

alternative. What is the relevance of trying to show that **C** would be better than **A** if **C** could be financed, if it cannot be financed, or if the administrative costs were not greater in **C**, if these costs are much greater, etc.?

This means that Menzel's analysis must be questioned. In **A**, the "given share of resources made accessible to the poor (their own resources, together with whatever public supplement)" (pp. 127-128), will most likely *not* be equal to what it is in **C**. Because of externalities of the decreased health care consumption, these resources will decrease, if the poor persons' increased consumption of other commodities does not compensate this by equal or greater externalities, which it probably would not. Furthermore, by the same reason, the resources of the non-poor will *also* decrease, even if their tax payment would be the same in **A** as in **C**, which Menzel seems to assume. If that is the case, welfare of the poor would decrease also because of the greater administrative costs in **C**. In addition to this, welfare could decrease because of "sympathy" for the decreased health care consumption of the poor.

Against this background, the assumption that the tax payments of non-poor persons would be the same in **A** as in **C** must be questioned. It seems more reasonable to assume that it would be *smaller* in **C**, which would decrease the "share of resources made accessible to the poor" in **C** even more.¹³

¹³ Menzel (1990, p. 126) notes that "[i]n a particular historical circumstance, of course, more and higher standard health care may be the only politically feasible way of getting additional resources to the poor". However, Menzel claims that "the public attitudes that restrict the government to that form of provision are the problem. Those are public attitudes, for which the public is still on the hook" (p. 126). This claim can be

5 Efficiency in resource allocation

As pointed out previously, it is reasonable to suppose that there will be differences between the tax amounts in **A** and **C**. Such differences could, of course, also mean differences in the efficiency in resource allocation between **A** and **C**. However, there is another difference between **A** and **C**, that is probably more important for efficiency in the resource allocation. A rational poor person would, isolated, prefer to shift part of her consumption of health care in **A** to other commodities. I have previously argued that this does not necessarily mean that the allocation in **A** is less efficient than the allocation in **C**, if efficiency is defined in terms of individual welfare, since there are externalities of health care consumption and people could have sympathy for other persons' health care consumption.

It could now be argued that the free public provisioning of health care in **A** will create incentive problems. People could take less precaution, or their demand could be unreasonably large, since health care is provided free. However, it can be argued that these problems are relatively small.¹⁴ It must also

questioned. It follows from my analysis that these attitudes could be completely rational, even in the conventional economic sense.

¹⁴ See, for example, Sen (1992, pp. 142-143): "... people do not typically wish to cultivate diseases, nor do they usually have much use for the specific medical and other facilities that may be on offer. To the extent that free or heavily subsidized medical facilities may make people take less precaution, there would of course be an incentive effect here too (since the difference here would be caused by a choice variable, to wit,

be noted that even if some persons' *demand* would be unreasonable, it would not necessarily lead to unreasonably large *consumption* in a health care system based on medical egalitarianism, in which the providers have an obligation to ration health care.

It can be argued that the incentive problems are more serious in **C**. It was previously noted that such a system means greater risks of abuse, since the assessment of a person's medical needs in the decision on the size of a person's equivalent amount of money would determine the person's consumption of *other* commodities. This would create strong economic incentives to increase the size of this amount, which could lead to quite perverse results.¹⁵

There is also another incentive problem in **C**. This problem originates from the fact that a poor person would not have consumed a part of her consumption of health care in the absence of the free public provisioning in **A**. Hence, this part of the consumption of health care in **A** will not negatively influence the poor person's economic incentives to work.¹⁶ However, in **C** there is no such

being careless), but in most circumstances and with most illnesses people are reluctant to take such risks just because the treatment itself would be free or inexpensive".

¹⁵ A person could, for example, have economic incentives to produce medical needs, especially such that would mean a great increase of the person's opportunity to consume *other* commodities than health care.

¹⁶ This was noted by Pigou (1932, pp. 725-726): "[T]ransference of objects not capable of being sold or pawned, and designed to satisfy needs, which, apart from the transference, a recipient would have left unsatisfied, have a different effect. The last unit of money which a man earns for himself in industry will be required to satisfy the same needs, and will, therefore, be desired with the same intensity as it would have

consumption of health care. It has been shifted to *other* commodities, which means that the person's economic incentives to work will be decreased.

This means that we have to consider also net welfare losses in the move from **A** to **C**, originating from economic incentives to increase the size of the equivalent amount, and from a net decrease in labour supply of poor persons as a result of the decreased economic incentives to work.

Menzel (1990, p. 128) notes that "even if assistance is provided in kind and not in cash, reference to the choices of rational poor people will be an important conceptual device in retaining a welfare state's respect for recipients' freedom".¹⁷ It can also be noted that this is also the case for the problems discussed in this and the previous section; these would exist even if the decreased consumption of health care and the equivalent increase of other consumption is not made by equivalent money transfers. All the above problems would exist, no matter if the other consumption is subsidised by cash aids or by assistance in kind.¹⁸

been if no transference had been made. Hence no contraction will occur in the contribution which, by work and waiting, he makes to the national dividend".

¹⁷ He also notes that "the rational poor person model does not necessarily end up endorsing cash aid in general" (p. 131n. 45).

¹⁸ The problem with the economic incentives to decrease labour supply in **C**, for example, originates from the fact that the poor person's consumption of other commodities than health care in **A** is not at all influenced by that part of the health care transfer in **A**, which the person would *not* have bought in the absence of this transfer. This would be a problem, no matter if the transfer in **C** is made in *cash* or in *kind*. In both cases, the transfer would, also for *this* part, increase the person's consumption of commodities, which the person would have bought in the absence of this transfer.

6 Choice motivated by other concerns than self-welfare

In my discussion, I have mainly discussed how *welfare* would be influenced by the move from **A** to **C**. Also much of Menzel's reasoning is concerned with this. Increased welfare is, of course, an important motive to choose an alternative. However, as noted previously, the prior consent model is, in the last analysis, convincing only if it is based on persons' *actual* consent. It cannot be excluded that a person has *other* goals than increasing her own welfare. A person could, for example, be committed to the principle of equal care for equal medical needs, and this could be a motive for this person *not* to consent to the move from **A** to **C**. Menzel claims that such a "caring argument" is "reflectively unstable":

Benevolence that takes the contributor's initial feelings as completely unquestioned, without any reflective or critical adjustment for the situation of the recipient, is surely morally superficial (Menzel, 1990, p. 122).

Attachment to [the high-sounding ideal of equal care for equal medical needs] is probably more a clumsy expression of shame about society's general distribution of income than a justified principle itself. The consent of rational poor persons is a far more relevant moral guidepost (p. 128).

In terms of the social states, previously defined, Menzel maintains that since the recipient prefers **B**, above **A**, a moral commitment of the contributor for **A** rather than **C** must be misguided.

On the contrary, I would argue that it would indeed be misguided to respect the recipient's preference for **B_i** above **A**, which Menzel's argument against medical egalitarianism essentially is based upon. This preference is *irrelevant* in the social choice between **A** and **C**. Even if a poor person would be better off in **B_i** than in **A**, she could be better off in **A** than in **C**, and even if she would choose **B_i** rather than **A**, she could choose **A** rather than **C**.¹⁹ Hence, a moral commitment for medical egalitarianism is not "reflectively unstable" if it does not consider the recipient's situation in the *irrelevant* **B_i**. It is the recipient's situation in the *relevant* social states, i.e. **A** and **C**, that should be considered in an assessment of how the recipient's situation actually would change by Menzel's proposed alternative to medical egalitarianism.

Commitment to medical egalitarianism would not necessarily be misguided even if poor persons were better off in **C** than in **A**. Increased *welfare* is, of course, an important reason to choose an alternative, but it cannot be excluded that a poor person would choose **A** even in this case. One reason could be a conviction that poor persons' *freedom*, or *capability*, would be greater in **A** than in **C**.²⁰

¹⁹ Menzel seems to exclude that this could be the case, see for example: "... why should we be allowed to restrict some technically free choice to preserve the fairness of other aspects of a situation if we do not thereby actually benefit the people who are unfairly situated? If people are poor, their reaction to the proposal to restrict their freedom to avoid protecting the larger unfairness of their situation should simply be to tell us to put up or shut up" (p. 126).

²⁰ On the concept of capability, see Sen (1999), in which also relevant references to previous works by Sen and others can be found (see, for example, pp. 308-314).

7 Concluding remarks

Menzel's claim that poor persons would prefer his proposed alternative to medical egalitarianism does not seem to be well-founded. Even if all poor persons, *isolated*, would prefer to shift part of their health care to other consumption, all poor persons could prefer the allocation in a system based on medical egalitarianism above the allocation that would be the outcome if *all* poor persons made such shifts.

Menzel's argument against medical egalitarianism can be questioned on several grounds.

1) Externalities of health care consumption are significant, which means that even poor persons, whose behaviour is perfectly rational in the conventional economic sense, could choose a health care system based on medical egalitarianism rather than one based on private insurance and income transfers to people with low income.

2) A person's *welfare* could, by "sympathy", be influenced by other persons' health care consumption, even if the person's *consumption* is not influenced, which could provide a second motive for a person to choose medical egalitarianism.

3) A person could, by "commitment", have *preferences* for other persons' health care consumption, even if the person's own *welfare* is not influenced. In economic analysis, a person's welfare preferences are commonly inferred from the person's choice preferences, and vice versa. This is often justified by *non-*

paternalism. However, if the person has *other* motives than increasing her own welfare, this convention in economic analysis must rather be classified as *paternalism*, since it implies that the person should have no other goals than increasing her own welfare.

4) Menzel's alternative to medical egalitarianism may not even be possible to finance. Even if it could, the administrative costs would probably be substantial.

5) Rational poor persons would decrease their labour supply in the move from medical egalitarianism to the proposed alternative as a result of decreased economic incentives to work, and the economic incentives to increase the equivalent amount of money would be strong, which would cause net welfare losses.

It follows that a person's, also a poor person's, preferences for medical egalitarianism could be motivated *exclusively* by a concern for her own welfare.

I have also argued that a contributor's commitment to medical egalitarianism is not "reflectively unstable" if it does not consider the recipient's situation in **B_i**.

What should be considered is the recipient's situation in **A** and **C**. Even if the recipient would choose **B_i** rather than **A**, he could choose **A** rather than **C**.

Hence, Menzel's main argument against medical egalitarianism is "reflectively unstable", since it is based on a comparison between medical egalitarianism and the situation in the *irrelevant* **B_i**, and not the situation in the *relevant* **C**.

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