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IS THERE A HEALTH-CARE PROBLEM IN WESTERN SOCIETIES?

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Abstract

The recent crisis in public finance that has characterized most Western countries has stoked renewed interest in the possibility of reducing government expenditure by reforming the health-care system. After reviewing the origins of today's state intervention in this field, the present paper argues that policy-makers will certainly strive to contain health-care of expenditure. Yet, it also claims that unless the ideological context that has favoured the birth and development of the current systems undergoes significant transformation, reform in this area is bound to remain elusive. In particular, the myth of social justice and the concept of human dignity need to be reassessed. The outcome of this process will determine to which extent state intervention in the health sector will lose its rent-seeking connotations, while increasing attention will underscore critical phenomena to which the principle of individual responsibility offers only limited solutions.

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1 Introduction: three dilemmas for public finance

Most advanced economies are currently experiencing severe problems with public finance. Their debt-to-GDP ratios frequently exceed the taxing 60% limit, and their deficits-to-GDP ratios are well above the dreaded 3% threshold.[1] Moreover, it is widely agreed that in many Western countries tax pressure has reached the limit, in that further increases would generate substantial tax evasion, discourage entrepreneurial risk taking and lead to loss of consensus for the incumbent political coalitions. As a result, decision-makers are confronted with three dilemmas.[2] First, they must choose whether to make an effort to stabilize their debt, or simply default, possibly forcing creditors to accept delayed reimbursement at reduced interest rates. Once choice falls on the first option (stabilization), policy-makers must then decide whether they want to increase taxation and risk losing consensus, or rather take action in order to decrease the expenditure/GDP ratio. Not surprisingly, the fear of losing power tends to prevail. The third dilemma, therefore, regards how to proceed in order to cut expenditure and/or enhance real GDP growth. In both cases, the problem boils down to reducing the weight of the welfare state in modern societies, e.g. by cutting redistribution, removing

[1] The Debt/GDP variable (α) stays constant when the ratio between new debt (d·Debt= the budget deficit) and new GDP (y·GDP) equals the old ratio α, that is when (d·Debt)/(y·GDP) = α, or δ/y = α, where δ=(d·Debt)/GDP. In this context, Buiter et al. (1993: 62-63) suggested that the thresholds mentioned in the text – the so-called Maastricht criteria − were determined (1) by assuming a long-run average annual nominal growth rate of 5% for the EMU area, (2) by following the "golden rule of public finance", according to which current expenditure ought to be financed by current revenue and (3) by observing that during 1974-91 public investment in the EC area was about 3% of GDP. Thus, if δ=3% and y=5%, the debt/GDP ratio does not explode as long as the initial debt/GDP ratio (α) remains within the 60% boundary.

[2] Surely, the dilemmas can be dissipated by inflating away the denominator of the α ratio (nominal GDP), a solution to which governments have frequently turned in the past by happily increasing the money supply. Yet, this seemingly convenient way out may not be viable when (1) creditors are voting citizens aware of the disarray and losses brought about by high inflation and/or (2) governments are unable to run large enough budget surpluses and are thus obliged to service maturing debt (interest and principal) by issuing new bonds and therefore asking lenders to come to their rescue.

privileges and guarantees: in a word, by drastically diminishing the role of government as a producer of goods and services as well as a regulator.[3]

Within this context, state-controlled and state-run health services deserve special consideration. On one hand, health care currently accounts for a significant share of public expenditure in the whole OECD area (about 14%). At first sight, therefore, it might appear an attractive candidate for cost-cutting reforms. Yet, its appeal should not be overestimated, especially – and paradoxically – in countries with problematic accounts. Returning to our previous remarks on the conditions for stabilization, an increase in public expenditure on health that would cause the budget deficit to jump from 3% to 4% of GDP would require a nominal 6.7% GDP growth rate in an economy with tolerable public debt (α=0.6), but a mere 4% GDP growth rate in a troubled country (where α>1). Furthermore, one should note that social insurance[4] has been one of the touchstones of the implicit social contract that has gradually taken shape in Western societies over the past one hundred years. Today, the presence of the state in health matters is characterized by intense ideological and psychological elements that enjoy worldwide recognition[5] and cannot be easily removed by technocratic

[3] The positive correlation between economic freedom (including deregulation) and growth is not discussed here. See for instance De Haan et al. (2006) as well as Czeglédi and Kapás (2009) for a rigorous review of the literature.

[4] Following Shapiro (2007: 11), we define social insurance as an institutional arrangement run by government. It aims at spreading across large groups of individuals the cost of harmful events and features three elements: compulsion, personal irresponsibility (premiums are not connected with expected costs) and regulated supply.

[5] See for instance articles 22, 25 and 29 of the Universal declaration of Human Rights. The declaration was approved by the General Assembly of the United Nations in December 1948. Article 22 guarantees the right to social security and of all social and cultural rights indispensable of the individual's dignity and the development of his personality. Article 25 establishes the right of everyone to a standard of leaving adequate for the health of himself and of his family. Article 29 makes the individual subject to those rules that are deemed necessary for the general welfare of a democratic society. The emphasis on health is not shared by many European constitutions. Yet, most European constitutions emphasize that individual freedom can be limited by the law or the public interest. For instance, while article 32 of the Italian Constitution explicitly declares that "the Republic safeguards health as a fundamental right of the

prescriptions. These two elements – the weak budgetary appeal in troubled countries and the momentous presence of resilient ideological components – explain why credible reform in this area requires first and foremost drastic changes in how people regard government intervention. Questioning the current notions of compulsory solidarity, shared liability and social justice – and possibly replacing them with those of human dignity, individual responsibility and natural rights – is more critical than impassive accounting exercises carried out by ministerial officials. As will be explained in these pages, coming to grips with these psychological and moral components will play an even bigger role when a third category of impediments is considered, i.e. the institutional costs of transition typical of a distorted economy. In short, the key issues are rent-seeking, inefficient judicial systems, social tensions, and they are easily dispelled by technocratic wands.

In particular, we posit that unless the ideological context undergoes significant transformation, reform in the health industry is bound to remain elusive. The downsizing of government in this area is surely likely to generate significant improvements in economic performance.[6] Yet, absent substantial ideological changes, the destruction of the deeply-rooted sociological components inherited from the past and of the current, pervasive rent-seeking mechanisms might provoke substantial short-run opposition, possibly shored up by pockets of unemployment and magnified by social unrest. Put differently, technocratic recipes are likely to generate institutional stalemate and diffused conflict, rather than efficiency-enhancing reform. The following sections aim at analyzing the main questions raised by these sets of issues and showing

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individual and as a collective interest", article 14 of the German Constitution states that the use of property "shall also serve the public good" and that "property and the right of inheritance … shall be defined by the laws".

[6] Privatized health care is clearly more efficient than the state-run alternative (e.g., Le Grand 2007): by giving people the power to choose, competition reduces shirking, leads to services of higher quality and also offers a powerful stimulus to the research and development of new drugs and treatments. In truth , there is a reputed literature, according to which the welfare state can enhance efficiency. Yet, event these authors emphasize that the state should redistribute income and wealth, and neglect the role of the state as a producer (Putterman et al. 1998).

that there can be no real solution, lest one clarifies the moral ambiguities typical of today's welfare states, health being no exception. With this vision in mind, section 2 examines the two original models that have inspired state intervention in the health-care industry during the 20th century; section 3 draws on this distinction in order to discuss the prospects for reform; section 4 elaborates on the role and dynamics of moral legitimacy. Section 5 briefly summarizes and concludes.

2 Bismarck, Beveridge and the role of government

The history and patterns of public intervention in the health system track two basic models. One originated from the paternalistic approach that characterized the legislation on social security introduced in the 1880s by chancellor Otto von Bismarck in Germany. According to this model, the state should ensure that all the working members of the nation are provided with minimum health services. Given the corporatist nature of society typical of the Second Reich, employers were thus required to establish and contribute to satisfactory sectorial insurance schemes, while the state would have regulatory and supervisory functions, for example with regard to the amounts and quality of the services provided. This vision does not exclude that the state might also choose to produce health care. Yet, the core of the Bismarck system is dominated by the presence of a set of private insurers created by – or connected with – employers, financed by employees and employers and supervised by the government. These insurers buy health services from private providers (e.g. doctors) and state providers (e.g. state hospitals) in order to cover the needs of workers and their families.

The second model is named after Lord William Beveridge, who formalized his proposals for a British National Health Service in 1942, although the system had actually been conceived by Lloyd George and Winston Churchill in 1911 and made operational by Aneurin Bevan in 1948 (Bartholomew 2004). The essence of the Beveridge system is fairly simple. The state provides comprehensive health insurance and services to all citizens, with no intermediaries. Supply must adapt to demand and demand follows the patient's perceptions and expectations about his own condition,

possibly filtered by the doctor's judgment and willingness to accept responsibilities for faulty diagnoses. Financing comes from general taxation. Within this context, private providers are not generally outlawed, but they are meant to be ancillary, bridging temporary government shortcomings and taking care of patients requiring high-quality accommodation standards.

These models are still with us today, albeit in different versions. In the Bismarckian context, for instance, sometimes the (paternalistic) state is no longer an intermediary and simply enforces the creation of personal health accounts.[7] In other cases the intermediary is a regional public authority, as in the Swiss cantons; and in most countries, insurance policies benefit from substantial government subsidies, as in the Netherlands. Everywhere, however, policy-makers inspired by Beveridge and Bevan had to back down from the universal ambitions of the founders. Thus, health services no longer cover all kinds of needs free of charge and local authorities might complement intervention by the centre, as in Italy. Yet, the main principles driving such two systems have not been questioned. The common assumption is that health is too important to fall victim to individuals' irrationality and propensity to cheat (lack of foresight and free riding on people's charitable instincts, respectively); to the budget constraints characterizing vast layers of the population; or to the vagaries of nature, for which nobody can be held liable. In the end – this is the traditional reasoning in favour of government intervention – social action must replace individual engagement and responsibility, and compensate for dishonesty or bad luck. In other words, state control on the provision of health services seems to have become part and parcel of a social

[7] According to this approach, each individual who does not subscribe to a life-time insurance plan is required to put aside a set amount of money during his working life. This sum is credited to an account that remains his property, matures interest, can only be utilized to buy health services and is transferable to other people if it is not fully utilized before passing away (see for instance Prewo 1996: ch. 4). A similar scheme – Medisave, supplemented with state-funded insurance against catastrophic illness – has characterized the Singapore health system since the mid-1980s (Ham 1996).

contract designed to obtain something desirable:[8] a contract that no person would turn down other than for cheating, greed, sheer ignorance or high transaction costs.[9]

No matter one's opinion about the explicit and implicit principles mentioned above, it is undeniable that when one observes reality, both models – Bismarck's paternalism and Beveridge's socialism – have performed rather well. Much as one might criticize national health programs for their inefficiency, most of them have met with unmitigated success in political terms. Certainly, there is plenty of anecdotal evidence documenting people's discontent with the kind of health-care they get. Yet, public opinion remains far from hostile to a health system controlled by the state.[10] Citizens do want better care (who wouldn't, if one has the illusion that it comes at little or no extra charge?), but most individuals do not advocate private service to replace state provision, and straightforward deregulation is not even on the agenda. Again, that is hardly surprising, since this attitude comes from a state of mind according to which health is considered a social right, rather than a service to be purchased; individuals should not be held responsible when hit by disease or accident, especially when medical treatments are available; society should devote more resources to compensate for people's vulnerability and biological weaknesses. In a word, poor health has become perceived as an unfair barrier to one's legitimate efforts to enjoy satisfactory living standards and maintain their social dignity. Thus, offsetting the "natural unfairness" of illness and physical incapacity has become a social duty (Allsop 1996, Fleurbaey and Schokkaert 2009). The upshot is that more drugs and medical care are demanded and the socially-conscientious decision-maker is expected to make them available.

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[8] Somewhat ironically, those advocating state intervention in order to compensate for individual cognitive failures and duplicity claim that they consider individuals "as caring human beings and sharing citizens rather than as self-interested consumer" (MacGregor 2005: 148).

[9] The nature of such costs will be clarified at the end of this section.

[10] Brown and Khoury (2009) present a 2009 Gallup poll covering OECD countries offering universal health coverage: it appears that 79% of the population were satisfied with the quality of healthcare in their city or area and 73% had confidence in their national healthcare or medical system. These percentages fall to 66% and 60% when the survey moves to countries that do not offer universal health coverage.

As we know, our elected representatives have thrust their hands deep into taxpayers' pockets and answered generously. Independent of the origin of the system (Bismarck or Beveridge), today's Treasuries cover a significant share of total expenditure on health. But this munificence has come at a cost: overall economic growth has been lower than anticipated and the room for maneuvering has been gradually shrinking. Worries for the future are thus well founded.

3 Grappling with budget constraints

To be fair, a purely Bismarckian context should present no major problems. If the health system is characterized by state paternalism, expenditure amounts to what it takes to define the content of the basic, compulsory health package that would do away with the consequences of individual misbehaviour (deviousness or lamentable stupidity); and enforce its purchase. The cost of defining a package monitoring that people actually buy it cannot amount to a very substantial sum. In fact, when Bismarck-related schemes face financial troubles – as in Germany or in the Netherlands in these years – their origins relate to the socialist elements they have absorbed through time, rather than to the traits of their initial scheme.

By contrast, the budget constraint features prominently in the system(s) created by Beveridge. In these contexts, financial pressure stems from demand- and supply-induced causes. With regard to demand, it is apparent that a community characterized by an increasingly idle population is likely to consume health services in ever greater quantities, especially when technological progress boosts expectations about outcomes and the role of the family as a care-taking institution weakens. More time is thus devoted to medical testing,[11] while mishaps or diseases formerly considered fatal in the past become the object of successful treatment, albeit sometimes at high costs.

[11] In particular, testing grows rapidly in order to reduce the probability of making mistakes and to shift at least part of the responsibility from humans to machines. This often leads to the higher costs typical of the so-called premium-medicine (Kling 2006). Moreover, testing potentially multiplies the number of people involved with a single patient, thereby making it harder to single out who is responsible for misjudgments or catastrophic decisions. Of course, this phenomenon is typical of all bureaucracies, especially when the judiciary tends to encourage patients' complaints.

Gatekeepers may be put in place, but they are only partially effective, since nobody wants to be taken to court by unhappy or greedy, opportunistic patients and their relatives; or to be harassed by ambitious magistrates eager to make headlines. As far as supply is concerned, the extensive rent-seeking activities carried out by overblown administrative structures, the well-entrenched groups of suppliers and the large numbers of unqualified or sluggish medical and paramedical staff are just too eager to meet demand, ask for additional resources, create new pockets of inefficiency. Granted, efforts to cut costs on the supply side have not been altogether fruitless: the introduction of competition among state providers, or between state and private providers, has indeed allowed the central planner to obtain valuable information about production costs and to avoid some wastage. But the gains in efficiency related to these experiments in "managed competition" are minor in comparison with the booming costs provoked by the increase in production driven by virtually unlimited demand.

In the end, first-come-first-serve rationing has been introduced to remedy the situation. As a result, waiting lists have become common in many countries, occasionally with dramatic consequences.[12] Furthermore, an increasing number of drugs and medical treatments are no longer free, even if subsidies remain significant. More generally, the public has accepted that society cannot afford to keep its socialist promise: whether or not health is considered a fundamental right of each individual, it cannot be provided in unlimited quantities to all members of the community. Instead, health (and welfare in general) has become the instrument through which, when strangled by budgetary hardship, the political class offers individuals a new deal, which could be named "targeted redistribution". It focuses on containing public expenditure by tweaking the rules of the game in important areas, such as pensions and education; and by introducing new health-policy criteria. These criteria would consist in targeting the adverse circumstances that can hardly be influenced by personal efforts, but seriously

[12] Emergency-room doctors have discretion in allowing patients to jump the queue, but they have no power to hire new doctors. As a result, patients often keep waiting their turn in emergency rooms, rather than at home. Not surprisingly, in order to avoid the worst, significant numbers of patients ignore state providers and flock to private health services or engage in medical tourism (Cortez 2008).

affect one's living standard, independent of the income class to which the individual belongs; and in heavily subsidizing the cost of bearing with such mishaps.

3.1 The stumbling blocks: three categories of transaction costs

So much for the efforts to contain expenditure. One may wonder, however, why the public generally stops short of advocating more radical change in the health sector. Why are state-managed charity and Rawlsian redistribution not enough, despite their greater transparency? Why has the state become engaged as a (rather inefficient) producer of health services? And how can we account for the deep resistance to move from social insurance to Rawls,[13] despite today's disillusionment with Beveridge's faith in the infinite wisdom and unfettered commitment of civil servants, the acknowledged weakness of the traditional argument based on the presence of market failures[14] and the increasing evidence about government dysfunctions?

As a matter of fact, the difficulties met by radical reform in this area come from the production side. In brief, and especially in the world of Beveridge, much of the state provision of health services has been powered by the decision-makers' ability to exploit people's trust in bureaucratic planning. Policy-makers have thus succeeded in (1) creating strong rent-seeking groups supporting and legitimizing further exercises in policy-making and (2) establishing new areas in which political élites gather consensus, develop alliances and offer privileges to their supporters. These two elements are critical, since when the social contract is framed in such a way that (1) and (2) are tolerated and perhaps even welcomed for a long enough period of time, Bismarck is

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[13] We refer here to Rawls's initial proposal, according to which the state should equalize monetary incomes across the population, without interfering with the structures of consumption and production.

[14] See for instance Scott (2001: 25-29) for a list of the traditional market failures that are assumed to justify government intervention in the health sector. The claim in favour of entrusting the state with producing merit goods is also weak. Those advocating Rawlsian redistribution confined to such goods can simply hand out non-transferable vouchers, rather than cash.

replaced by Beveridge and three categories of transaction costs make backpedaling all but impossible. These are the cost of agreeing on a new and more transparent redistributive covenant; the cost of dealing with the social tensions provoked by rent-seeking groups whose privileges are threatened; and the cost of interacting with a poor judicial system. The first two points are obvious. As noted above, the state provision and administration of health services is accompanied by the rise of powerful interest groups that gradually transform their status into sets of privileges. Poor skills or shirking are the most visible consequences, as well as their unwillingness to operate in a competitive environment. Furthermore, this system offers political élites opportunities to consolidate and possibly expand their power, e.g. by expanding the bureaucracy. None of these groups will give in without a fight. With regard to the third component, we argue that when choosing between a privately operated system (perhaps complemented by transparent income transfers) and a state-operated system, citizens face a rather simple alternative. Either they deal with possibly sluggish state employees under little pressure to economize on costs; or they confront private insurers that might offer better care, but are also eager to contain costs and likely to create conflicts to be solved in court, which can often be expensive, time-consuming and frustrating. Choosing between the two scenarios is not obvious. A snail-paced counterpart who eventually gives in to most your requests might well be preferable to a tough guy who challenges you to go to court and for whom the marginal cost of doing so is very low. In other words, spending your time persuading a bureaucrat is not necessarily inferior to wasting your time and your money in court.

3.2 From the illusion of bureaucratic wisdom to managed competition and targeted redistribution

If our analysis is correct, the future of the traditional European welfare state is relatively easy to characterize. On one hand, it is clear that despite much drum banging for improving managed competition and absent fundamental changes in public views about the scope of personal responsibility vis-à-vis health care, significant results will follow only if demand is severely restrained by rationing and/or by mimicking market pricing.

In fact, and rather ironically, in several cases managed competition has indeed become a euphemism for these very measures.[15] On the other hand, the core of the debate will have to move from finding out how to manage competition more effectively, to defining the kinds of treatments that deserve to be funded by the state (targeted redistribution). Finally, the outcome will also depend on the size of the incumbent rent-seeking coalitions, which are particularly burdensome where socialist schemes prevail and which can easily abort most reforms. For instance, rather than being a useful device to keep expenditure under control (as in the Bismarckian context), targeting under Beveridge might well focus on ensuring that jobs and inefficiencies in the public sector are preserved.

To summarize, Bismarckian countries could move their national health scheme towards a "targeted redistribution" pattern with no great trouble. In their case privatization is clearly a feasible option, since the rent-seeking elements are neither too strong, nor too harmful. True, public opinion can hardly see its necessity, but that is another story. By contrast, in the world of Beveridge the real beneficiaries of the system are first and foremost the administrators of those programmes and the politicians, followed by a significant portion of the providers and the suppliers involved, among whom shirking and overpricing are widespread. These groups might not resist the introduction of market pricing into the welfare system (managed competition or specific forms of targeted redistribution), but in order to protect their privileges they are bound to oppose privatization and competition vigorously.

Unfortunately, those who have an interest in galvanizing against these coalitions hesitate, and for good reason: they fear the transaction costs mentioned earlier and they

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[15] A telling example has been provided by the proposal to reform the British NHS put forward by Cameron's government in January 2011. According to this plan, health would still be supplied free of charge, but it would be provided by consortiums of doctors. These consortiums would be allotted a budget and a price list with which the buyers (i.e. the doctors, on behalf of their patients) must comply. Of course, once the budget has been spent, patients should not get sick until the funding for the next year is approved and made accessible.

sensibly mistrust politicians' assurances about the benefits (lower tax rates or offsetting income transfers). Certainly, people are no longer taken by the socialist illusions of happiness free of charge. Yet, they are still persuaded that they have struck a deal, in that by paying taxes they have subscribed to a soft social contract which includes a set health package more or less independent of the subscribers' incomes. Politicians are their counterparts. And politicians have an interest in ensuring that the package is as generous as (financially) possible and in relieving the citizen of several irksome incumbencies: deciding how much consumption should be sacrificed in order to pay for health; choosing an adequate provider; comparing prices; engaging in preventive care; taking doctors to court should one feel duped and going through the pains of an ineffective judiciary. In short, people have accepted the premise that health is "too important" to be decided by private individuals; thus, they are focused on wanting to reduce transaction costs – information gathering, choosing and planning, enforcement – and are convinced that their current arrangement meets their needs. As a consequence, they are willing to consider changing the details of the current health-care system, and possibly accept some restrictions, but they do not wish to abandon it and incur the cost of fighting daunting rent-seeking coalitions. This explains why there are plenty of demands for reforms, improvements, rationalization; much less for drastic changes.

4 Justice and human dignity

Should we then conclude that economic hardship will not suffice to induce politicians to privatize our national health programs? As hinted in the introductory section, we believe that unless a radical change in attitudes is brought about, the answer is indeed in the negative. Individuals in paternalistic contexts don't see the need for change, since in those countries public finance is still under control. On the other hand, although people in socialist contexts face much tighter constraints, they do not believe that health-care

reforms will offer adequate solutions to their public-finance problems[16] and eventually back down when confronting the risk of downsizing the rent-seeking structure. Public opinion does seem to realize that stabilizing public indebtedness without freezing public expenditure is going to be difficult. Nonetheless, the economic incentives to intervene on state health-care do not seem compelling: keeping public expenditure on health under control will be important, but freezing it or revolutionizing the system is not deemed essential. For instance, state pensions are considered a much more promising target for cost-cutting exercises.[17]

Yet, the environment is not totally static. The crisis of the welfare state is manifest and its primary justification – the myth of social justice – begins to be the object of closer scrutiny. The moral validation for public health is no exception: in fact, the future of our health-care systems will eventually depend on the shared assessment of two interrelated issues: the concept of justice (which defines equality and social fairness) and the relationship between the concepts of justice and human dignity. The remaining parts of this section will address such two questions and explore how individuals might alter their perceptions in this regard.

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[16] The evidence in the UE15 area during the past decade shows that the ratio of public expenditure on health to GDP in the two groups of countries is roughly the same, with Greece and Spain (both Beveridge) at the low end, and Germany and France (both Bismarck) at the top end.

[17] Intervention in this area may also have positive effects on growth (Eberstadt and Groth 2007). Not surprisingly, as long as individuals retire at a constant age, but their life gets longer, their burden on social care (including health care) increases. By contrast, if the "old" cohorts were allowed to stay active, health-care could become a profitable social investment, rather than a drag on collective consumption and a burden to taxpayers.

4.1 Justice, equality and the Aristotelian perspective

According to its most discriminating advocates, a compulsory, universal and state-financed health-care system is legitimized by its intrinsic morality.[18] Their point of departure is Aristotle's vision, according to which "just" means "consistent with and enhancing human nature" and – in turn – "human nature" is synonymous with "flourishing", i.e. with one's inner drive and right to discover and realize his personality. In this light, therefore, government intervention is morally justified and possibly imperative when it is designed to remove the impediments along one's path to flourishing. It follows that justice and equality boil down to the same idea, the right to engage in the flourishing process free from normative barriers and violence. In particular, a society is just if all its individuals are granted this condition. This is in fact the essence of the Aristotelian notion of equality.

Now, the twist added to justify the environment advocated by Beveridge and Bevan consists in identifying flourishing either as a known final state, or as a set of desirable traits that the individual should enjoy when engaging in flourishing. Thus, this kind of flourishing – let us call it "social" flourishing – is not the process through which the individual discovers and possibly realizes his inner nature. Instead, it defines the specific features of the outcome that the individual attains. Likewise, from this vantage point, a just institutional context is not one in which individual freedom is guaranteed, but rather one that ensures that those outcomes are obtained by all the members of the community (Sen 1999). This is the essence of (social) justice and (social) equality. Health and socialist health-care fall squarely within this perspective, since it is obvious that sick people would find it hard (or harder) to flourish, both because their illness restrains their actions and because absent state intervention, the necessary treatments would absorb resources that otherwise would be devoted to pursuing the outcomes they would like to secure (social flourishing). Not surprisingly, according to this view, state intervention in health matters can thus be inefficient and even disappointing, but its role cannot be denied. Government regulation and production in this field might be subject

[18] See for instance Ruger (2004 and 2007) for a clear statement of this thesis and references to the relevant literature.

to changes and improvements, but they cannot be removed from the centre of the stage. Yet, however simple and demagogically attractive it might appear, we posit that this view is operationally ineffective and conceptually flawed.

Its operational weaknesses stem from the fact that social actors in a world affected by scarcity choose among different desirable ways of enhancing their intellectual budding and growth. This is actually what flourishing is about – the individual discovery of one's self. A person might focus on health, another one might want better education, a third one might require a guaranteed income and enough leisure to engage in a life of meditation free from earthly worries and hassles. In a word, there are many ways of flourishing and no clear criteria to rank the final results. By contrast, there are many ways of discouraging flourishing, all of them deplorable. For instance, denying an individual his freedom to choose and depriving him of his earned income are surely among such ways. Yet, these are the very essence of regulation and taxation. Of course, deferring to the political process – public reasoning and democratic decision-making, as Ruger (2004) suggests to her readers – adds to the confusion. As we have mentioned in the earlier sections of this article, rather than enhancing conscious choice and individual responsibility, the enforcement of social justice opens the door to – and encourages – discretion, opportunism and rent-seeking. Whatever the legitimacy of policies inspired by social flourishing, and whatever its moral foundations (which we will discuss shortly), the instruments to obtain social justice favour the birth of privileges, rather than individual fulfillment.

From the conceptual vantage point, the Aristotelian interpretation put forward by the supporters of social flourishing overlooks that the philosophy of flourishing stems from a natural-law approach, not from centrally-designed priorities. In particular, the notion of natural law underlying the process of Aristotelian flourishing is the principle of freedom from coercion (ownership of one's self and sacredness of property rights):[19] it does not consist of a set of positive rights, nor is it a list of desirable goods and services

[19] See for instance Wright (2000), who offers a critical survey of the Aristotelian natural-law tradition spanning Aristotle, Aquinas, Kant and Finnis.

to which a society should grant free access. Surely, the fact that such sets and lists are prepared by enlightened elites or are agreed upon through majority voting is not enough to make them "right" or "natural". Likewise, it would be mistaken to argue that flourishing can only be social and that it can only take place within a context featuring bundles of positive rights and their corresponding obligations falling upon those who must fund them. Instead, the Aristotelian meaning of "flourishing" refers to the purpose of life as the individual perceives it. It is the pursuit of virtue (*eudaimonia* or self-fulfillment) through a process characterized by choice, as well as by trial and error. Put differently, the purpose of a society ruled by natural law is to ensure that its members can freely engage in their ongoing discovery processes punctuated by luck and accidents, driven by a subjective evaluation of the outcomes, and characterized by the material rewards and punishments produced by the market process. Of course, the discovery and realization of one's self can be enhanced by interacting with other individuals (society). Nonetheless, the yardstick of flourishing remains the individual, since *eudaimonia* is definitely an individual perception and the point of arrival an individual journey. Surely, the journey takes place in a social environment. Yet, it remains an individual experience. The so-called social good, therefore, is neither an outcome nor an aggregate objective to be pursued by a community (or its representatives). Instead, it is an institutional arrangement within which agents are free to choose, exchange, and interact in their attempts to discover their nature and realize their potential.

4.2 Justice and human dignity

The upshot of the previous subsection is that in the Aristotelian world the individual is indeed a social and political animal, since interacting with other human beings is a key component of his flourishing. Yet, government has nothing to say about outcomes and relatively little about the way a person's flourishing unfolds. In fact, the Aristotelian perspective suggests that the role of the state is to ensure that men remain free to choose, that they are not hampered in their search for knowledge and that the driving (and self-correcting) mechanisms of individual responsibility are not tampered with. By

and large, this amounts to the well-known negative notion of justice: “just” is the opposite of “unjust”, and “unjust” is what violates the freedom-from-coercion principle.

In this light, the ideas of justice, equality and human dignity are equivalent, for human dignity is in fact the (natural) right of being what one is, of being the owner of himself, of choosing according to one’s own inclination, no matter whether other people believe in priorities dictated by alleged meta-principles (e.g. religion or race), or by political processes (e.g. majority or supermajority decision-making). Men can benefit from advice and guidance. But the decision to follow or to reject guidance remains one’s responsibility. Thus, there can be no justice without human dignity and there can be no human dignity without personal responsibility. By denying the freedom to choose, state intervention has then offended both justice and human dignity. In particular, as a result of taxation, regulation and production of merit goods, flourishing has become a social endeavor, rather an individual discovery; the rise of the rent-seeking coalitions has emptied the notion of social equality; and compulsory redistribution has violated the principle of equality broadly understood, since compulsory redistribution implies that human dignity is less and less important as one becomes richer. Put differently, state intervention implies that choice has been removed from the individual and that individual responsibility is necessarily crowded out by arbitrary social criteria. In the end, individual decision-making has been replaced by the world of politics and all but unaccountable bureaucracies.

The moral assessment of human nature and social interaction does not change its features when one focuses on health. Good health is of course desirable, but it comes at a cost. As a consequence, it becomes the object of choice, clearly more difficult and painful for the poor than for the rich. Yet, if one accepts the principles of flourishing and human dignity (justice), one must also accept that flourishing might not exhibit the same features for everybody, and that the meta-principle of justice has nothing to do with end states. Flourishing within a just institutional context does not identify a specific and objective goal, unless one calls “virtue” or *eudaimonia* a goal. Even less can one identify flourishing with the attainment of material targets, such as a given living standard, a minimum GDP per capita or other similar variables. The principles of

justice and human dignity are end/goals in the sense that they are guarantees that enhance our freedom to choose, protect us against the possibility of being forced to serve somebody else's goals and prevent others from aggressing our right to pursue virtue. Those advocating state intervention in the realm of health, therefore, cannot appeal to the notions of justice or human dignity, since socialist health-care is in fact manifestly inconsistent with those very notions – and thus immoral.[20]

4.3 Where do we go from here?

As we pointed out earlier, it is unlikely that state intervention in the health industry will be downsized because of financial stringency. It will be capped and gradually reformed, but the health budget *per se* is unlikely to cause major turnarounds. Nonetheless, it is a fact that people have lost faith in the bureaucrats' ability to promote happiness and create wealth. Disillusion has already turned into mistrust, as generalized resentment against taxation and privileges mounts, and political disenchantment increases. For present purposes, therefore, the challenge is to assess what it takes to transform resentment into illegitimacy and whether this changeover might be sparked in – or perhaps by – the health industry.

A social arrangement loses legitimacy when it is generally perceived as unjust and the search for alternative, fairer solutions takes off. Thus, in order to answer the first question, we should start from investigating how people perceive the notion of justice and what drives its dynamics. The answer to the second question will follow as an extension of those insights.

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[20] The verdict is perhaps less harsh with regard to the paternalist approach, which *de facto* denies the principle of human dignity in the presence of genetically induced shortsightedness and thus admits that, when it is apparent that shortsightedness leads to mistakes that are systematically regretted *ex post*, society might interfere with one's flourishing. The burden of proof remains however on the advocates of paternalism, who would be required to show that flourishing is hampered by some kind of genetic bias resilient to man's evolutionary history and that "genetic mistakes" are not just a way of asking for subsidies after one has engaged in a gamble and lost.

In their wide-ranging survey on the perception of justice, Robinson et al. (2007) have clearly and persuasively shown that individuals are genetically programmed to develop a sense of justice from the very early stages of their lives. This could be defined as “core justice”, according to which our sense of right and wrong comes from our genes and originates from an evolutionary process spanning millennia. But there is also a second layer of moral assessments, which is heavily influenced by the environment and gives substance to “consequentialist justice”. Consequentialist justice identifies a mechanism through which the individual understands and accepts an institutional context which has proven to be stable, diffuses social tensions and offers desirable opportunities for interaction. For instance, physical aggression and armed robbery are considered violations of core justice. By contrast, some forms of opportunism (holding out, tax evasion or some forms of free riding) are offenses against consequentialist justice. To be fair, it is not always easy to draw the line. On the one hand, when consequentialist justice consolidates through hundreds of generations, evolution is most likely to transform its principles into core justice: in these cases, successful routines cease to be instruments and become moral principles. On the other hand, it may well happen that some elements of core justice are sidestepped when they are manifestly conducive to conflicts and economic decline: over time some ethical principles are thus shelved as moral anachronisms. Likewise, some institutional arrangements may no longer satisfy their original purpose or live up to expectations. If so, they lose their legitimacy and may decay, especially when their moral foundations contrast with core justice.

For our purposes, one may observe that the principles of fairness and social justice that have characterized widespread support for the European-styled welfare states over the past decades are too recent to be part of core justice. Therefore, since these principles are not embedded in our genetic pool, they could be revised or simply rejected relatively rapidly. What about health? Does this apply to our views on the provision of health-care as well?

From a historical perspective, charity directed at other members within the community has usually been considered a moral duty of the individual, especially when sick people

are involved. Yet, we doubt that it has ever been an element of core justice to be enforced at all costs. Surely, mean behaviour has frequently provoked moral disapproval, but until the beginning of the 20th century it never justified the use of violence. Governments were not legitimized in forcing individuals to be charitable against their will. By contrast, and consistent with the rise of the doctrine of social equality, in the second part of the past century democracy has rapidly been accepted as the most desirable political structure. Sharing the common wealth, therefore, has turned up to be (consequentially) just, since it has been regarded as part and parcel of the democratic context and of the social contract it implied. Furthermore, compulsory sharing did not create major tensions with our sense of core justice. Easy access to health care was (and is) consistent with our sense of moral obligation; and it was made bearable by adequate rates of economic growth, so that a high degree of redistribution did not reduce the disposable incomes of those who were supposed to foot the bill. Today, however, the balance between the core and the consequentialist components of justice seems to have become more fragile. As long as we agree that government intervention in health matters is justified by consequentialist justice, and once it becomes apparent that such intervention does not meet people's expectations, state-managed health-care loses at least part of its legitimacy. Thus, if the conflict with the shared notion of core justice sharpens, the underlying institutional context will be perceived as obsolete and will eventually undergo radical reform.

We conjecture that nowadays the case for consequentially-just health care might actually be facing a crisis. True, most people would not articulate their apprehension in terms of justice and are rather inclined to frame it in terms of financial stringency. Yet, one cannot deny that the debate about institutional inadequacy is already under way. The value of democracy as an effective device to avoid violence by the autocrat is not disputed; but it is also increasingly apparent that its substitute – violence made legal by majority consensus – is not always regarded as just in the term's core sense. Disenchantment and unease follow: people realize that income redistribution is not equivalent to wealth sharing and that rent-seeking meets neither consequentialist, nor core justice. Put differently, the more the health-care system is perceived as a

playground for rent-seeking activities and the higher its cost in a stagnant economic environment, the more clearly its social(ist) components appear unjust. Should this come to pass, looking for alternatives would no longer be understood as a betrayal of an alleged social contract, but rather as the search of new ways of conceiving of legitimate social arrangements and of reducing the gap between moral relativism prompted by expediency and our core sense of justice. Health remains indeed a special area in the assessment of one's moral obligations towards the other members of society, but the justification for a socialist solution would definitely lose the appeal it had at its birth. In short, social concerns for human flourishing might be about to backfire. Rather than enhancing spiritual alertness and individual flourishing, social concerns for flourishing have generated rent-seeking structures, multiplied transaction costs and – more importantly – created tensions with our (sleeping) sense of core justice.

5 Summary and conclusions

In the recent past, much of the debate on the looming breakdown of government finances in large parts of the Western world has focused on finding acceptable ways of containing public expenditure and possibly raising taxation. The accepted strategies on the expenditure side can be summarized in three lines of action: reforming the state-pension system, freezing the budget for education, and containing health-care costs. Yet, reality seems to be unfolding in a different direction and the recent financial crisis has helped to understand why: an overblown socialist environment leads to collapse when the economy loses flexibility and fails to transform technological opportunities into entrepreneurial ventures and thus growth.[21] Public expenditure is indeed problematic. But low growth and stagnation are worse. As history confirms, when it comes to reducing the expenditure/GDP ratio, expanding the denominator is more important that squeezing the numerator. Put differently, hope of avoiding bankruptcy rests with the ability to grow, which requires a new notion of fairness, extensive

[21] In particular, the recent financial crisis has shown that the larger the welfare state, the lower the chances of reacting to structural adversities and the greater the need to downsize it.

deregulation, deep reform of most tax systems and the drastic downsizing of the incumbent rent-seeking structures. Future redistribution will not have to reproduce hypothetical choices made behind a veil of uncertainty, but instead make it easy for people to bridge the gap between their starting points and a set of minimal socially shared goals (the essence of targeted redistribution). Despite its weight, therefore, the cost of government intervention in the health-care industry is not the main source of problems for our welfare systems. True, if it came to the worse, gradual transition would offer the obvious technical solution: as the axe falls on subsidies, patients' claims to the right of choice among competing providers would be favoured, opting out of mandatory health contracts encouraged and the size of state-managed health-case supply downsized following the decline in demand. Yet, we have tried to show, all this is unlikely to happen, for transition is barred by the strong and deep rent-seeking structures that today characterize most health systems grown along Lord Beveridge's tradition or that have absorbed some of its elements. These sizable and powerful groups of privileged individuals ensure that privatization remains politically difficult to obtain, while high transaction costs and limited trust in the judiciary keep the pressure for transition low. That explains not only why the world of Beveridge is not sustainable, but also why it won't be abandoned unless people change their perception of the role of the state and/or the most detrimental features of rent-seeking are deemed intrinsically immoral and thus delegitimized.

This is actually the second element to which we have drawn attention: transition to light forms of paternalism or to an outright free-market conception remains problematic as long as it can rely on consequentialist justice. Until recently, generic claims in favour of efficiency and public finance have not been compelling enough to accept privatization. Decade after decade, the rent-seeking game has succeeded in producing large coalitions of winners (political elites and civil servants) and very large groups of people who did not really know whether radical reform will see them on the winning or the losing side. These large groups have now come to realize that transition would make society better off in the medium and long run. Yet, as societies grew old, the relevant time horizon for the median individual became shorter and the prospect of taking a chance and suffering the cost of transition less exciting: the temptation to free ride on the next generation

(that will inherit our debt) proved all but irresistible. This was of course both rational and hypocritical. Sadly enough, by arguing in favour of social fairness and by preferring rent-seeking to growth, we have actually obliged our children to work for our creditors or to declare bankruptcy. That very rent-seeking game, however, has seriously hampered our prospects for growth, and today's financial stringencies might change our perspective once again. If that happens, the consequentialist connotation of social justice might crumble. Should this happen, large chunks of the welfare state – including government production of health-care – might collapse and the notions of human dignity and individual responsibility might regain centre stage in the unfolding of our civilization.

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