Is There a Health-Care Problem in Western Societies?

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Most advanced economies are currently experiencing severe problems with public finance. Their debt to gross domestic product (GDP) ratios frequently exceed 60 percent, and their deficit to GDP ratios are higher than the dreaded 3 percent 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

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1. The Debt/GDP variable α stays constant when the ratio between new debt ($d \cdot$ Debt = the budget deficit) and new GDP ($y \cdot$ GDP) equals the old ratio α—that is, when $(d \cdot \text{Debt})/(y \cdot \text{GDP}) = \alpha$, or $\delta/y = \alpha$, where $\delta = (d \cdot \text{Debt})/\text{GDP}$. In this context, Willem Buiter, Giancarlo Corsetti, and Nouriel Roubini suggest 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 percent for the Economic and Monetary Union 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 European Community area was about 3 percent of GDP (1993, 62–63). Thus, if $\delta = 3$ percent and $y = 5$ percent, the debt/GDP ratio does not explode as long as the initial debt/GDP ratio α remains within the 60 percent boundary.

2. The dilemmas surely 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 or (2) governments are unable to run large enough

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delayed reimbursement at reduced interest rates. Once choice falls on the first option (stabilization), policymakers must then decide whether they want to increase taxation and risk losing consensus or take action to decrease the expenditure/GDP ratio. The fear of losing power, not surprisingly, tends to prevail. The third dilemma, therefore, regards how to proceed in order to cut expenditure or enhance real GDP growth. In both cases, the problem boils down to reducing the weight of the welfare state in modern societies—for example, by cutting redistribution and removing privileges and guarantees, in other words by drastically diminishing government's role as a producer of goods and services and as a regulator.[3]

Within this context, state-controlled and state-run health services deserve special consideration. Health care currently accounts for a significant share of public expenditure in the whole Organization for Economic Cooperation and Development (OECD) area (about 14 percent). 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. With regard to my previous remarks on the conditions for stabilization, an increase in public expenditure on health that would cause the budget deficit to jump from 3 percent to 4 percent of GDP would require a nominal 6.7 percent GDP growth rate in an economy with tolerable public debt ($\alpha = 0.6$), but a mere 4 percent GDP growth rate in a troubled country (where $\alpha > 1$). 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 state's presence in health matters is characterized by intense ideological and psychological elements that enjoy worldwide recognition and cannot be easily removed by technocratic prescriptions.[5] 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

budget surpluses and are thus obliged to service maturing debt (interest and principal) by issuing new bonds and therefore by asking lenders to come to their rescue.

3. The positive correlation between economic freedom (including absence of regulation) and growth is not discussed here. See De Haan, Lundström, and Sturm 2006 as well as Czeglédi and Kapás 2009 for a rigorous review of the literature.

4. Following Daniel Shapiro (2007, 11), I 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 it features three elements: compulsion, personal irresponsibility (premiums are not connected with expected costs), and regulated supply.

5. See, for example, Articles 22, 25, and 29 of the Universal Declaration of Human Rights approved by the General Assembly of the United Nations in December 1948. Article 22 guarantees the right to social security and 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 living adequate for his own health and his family's. Article 29 makes the individual subject to those rules deemed necessary for the general welfare of a democratic society. Many European constitutions do not share this emphasis on health, yet most European constitutions emphasize that individual freedom can be limited by the law or by the public interest. For example, whereas Article 32 of the Italian Constitution explicitly declares that "the Republic safeguards health as a fundamental right of the 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."

requires 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 notions of human dignity, individual responsibility, and natural rights—is more critical than impressive accounting exercises carried out by ministerial officials. Coming to grips with these psychological and moral components will play an even bigger role when a third category of impediments is considered—namely, the institutional costs of transition typical of a distorted economy. In brief, the key issues are rent seeking, inefficient judicial systems, and social tensions, and these issues are not easily dispelled by waving technocratic wands.

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 likely to generate significant improvements in economic performance.[6] Yet, absent substantial ideological changes, the destruction of the deeply rooted social programs inherited from the past and of the current pervasive rent-seeking mechanisms will provoke substantial short-run opposition, possibly shored up by pockets of unemployment and magnified by social unrest. Put differently, technocratic fixes are likely to generate institutional stalemate and diffused conflict rather than efficiency-enhancing reform.

In this article, I analyze the main questions raised by these sets of issues and show that no real solution is possible unless one clarifies the moral ambiguities typical of today's welfare states, including its health-care programs. With this vision in mind, I examine the two original models that inspired state intervention in the health-care industry in the twentieth century, draw on this distinction to discuss the prospects for reform, and elaborate on the role and dynamics of moral legitimacy.

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 that chancellor Otto von Bismarck introduced in the 1880s in Germany. According to this model, the state should ensure that all 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, and the state would carry out regulatory and supervisory functions, for example, with regard to the amounts and quality of the services provided. This vision does not exclude the

6. Privatized health care is clearly more efficient than the state-run alternative (see, for example, Le Grand 2007): by giving people the power to choose, competition reduces shirking, leads to higher-quality services, and strongly stimulates the research and development of new drugs and treatments. Of course, some writers have argued that the welfare state can enhance efficiency, but they emphasize that the state should redistribute income and wealth, and they neglect the state's role as a producer (Putterman, Roemer, and Silvestre 1998).

possibility of state-produced health care. Yet the core of the Bismarck system is dominated by private insurers that are created by or connected with employers, financed by employees and employers, and supervised by the government. These insurers buy health-care services from private providers (for example, doctors) and state providers (for example, state hospitals) in order to meet 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. Lloyd George and Winston Churchill had conceived the system in 1911, and Aneurin Bevan put it into operation in 1948 (Bartholomew 2004). The essence of the Beveridge system is simple. The state provides comprehensive health-care 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 higher-quality accommodation standards.

These models are still with us today, albeit in different versions. In the Bismarckian context, for example, sometimes the (paternalistic) state is no longer an intermediary and simply enforces the creation of personal health accounts. In this approach, each individual who does not subscribe to a lifetime 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 and matures interest; it may be utilized only to buy health services, and it is transferable to other people if it is not fully utilized before the individual dies (Prewo 1996, chap. 4).[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, policymakers inspired by Beveridge and Bevan have had to back down from the system founders' universal ambitions. Thus, health services no longer cover all kinds of needs free of charge, and local authorities complement intervention by the center, as in Italy.

Yet the main principles of such systems have not been questioned. The common assumption is that health is too important to be allowed 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 that characterize vast layers of the population, or to the vagaries of nature, for which nobody can be held liable. In the end, according to the traditional reasoning in favor of government intervention, social action must replace individual engagement and responsibility

7. A similar scheme—Medisave, supplemented with state-funded insurance against catastrophic illness—has been used in Singapore's health system since the mid-1980s (Ham 1996).

and compensate for dishonesty and bad luck. In other words, state control on the provision of health services seems to have become part and parcel of a social 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.

Regardless of one's opinion about these explicit and implicit principles, it is undeniable that when one observes reality, both models—Bismarck's paternalism and Beveridge's socialism—have performed well. Much as one might criticize national health programs for their inefficiency, most of them have met with unmitigated success in political terms. There is certainly 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 state-controlled health-care system.[9] Citizens want better care (Who wouldn't if it can be obtained 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 finding is hardly surprising because this attitude comes from a state of mind according to which health care 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 come to be perceived as an unfair barrier to people's legitimate efforts to enjoy satisfactory living standards and to 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 people demand more drugs and medical care, and the socially conscientious decision maker is expected to make them available.

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

Grappling with Budget Constraints

To be fair, a purely Bismarckian context should present no major problems. If the health-care system is characterized by state paternalism, expenditure amounts to what

8. Those who advocate state intervention in order to compensate for individual cognitive failures and duplicity claim somewhat ironically that they see individuals "as caring human beings and sharing citizens rather than as self-interested consumer" (MacGregor 2005, 148).

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

it takes to define the basic, compulsory health-care package that would remedy the consequences of individual misbehavior (deviousness or lamentable stupidity) and to enforce its purchase. The cost of defining a package and monitoring people's purchase of it cannot amount to a very substantial sum. In fact, when Bismarck-oriented schemes face financial troubles, as in Germany and the Netherlands in recent years, these troubles spring from the socialist elements that the systems have absorbed through time rather than from the traits of their initial scheme.

By contrast, 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 family's role as in caretaking weakens. More time is thus devoted to medical testing,[10] and accidents and diseases formerly considered fatal come to be treated successfully, albeit sometimes at high costs. Gatekeepers may be put in place, but they are only in part effective because 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 number of unqualified or sluggish medical and paramedical staff are only too eager to meet demand, ask for additional resources, and 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 and between state and private providers has indeed allowed the central planner to obtain valuable information about production costs and to avoid some waste. 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 served" rationing has been introduced to remedy the situation. As a result, waiting lists have become common in many countries, occasionally with dramatic consequences.[11] Furthermore, increasing numbers of drugs and medical treatments are no longer free, even if subsidies remain significant. The public has accepted more generally that society cannot afford to keep its socialist promise:

10. 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 shift often leads to the higher costs typical of the so-called premium medicine (Kling 2006). Moreover, testing potentially multiplies the number of people involved in caring for a single patient, thereby making it more difficult 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.

11. 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. In order to avoid the worst, significant numbers of patients not surprisingly ignore state providers and flock to private health services or engage in medical tourism (Cortez 2008).

whether health is considered a fundamental right of each individual or not, 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 the political class, when strangled by budgetary hardship, offers individuals a new deal, which might be called "targeted redistribution." This redistribution focuses on containing public expenditure by tweaking the rules in important areas, such as pensions and education, and by introducing new health-policy criteria. These criteria seek to target the adverse circumstances that can hardly be influenced by personal efforts but that seriously affect one's living standard, independent of the income class to which one belongs, and to heavily subsidize the cost of dealing with such adversities.

Stumbling Blocks: Three Types of Transaction Cost

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-care 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 moving from social insurance to Rawls,[12] 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,[13] and the increasing evidence of government dysfunctions?

In fact, the difficulties met by radical reform in this area come from the production side. Especially in the Beveridge world, much of the state's provision of health services has been powered by the decision makers' ability to exploit people's trust in bureaucratic planning. Policymakers have thus succeeded in (1) creating strong rent-seeking groups that support and legitimize further exercises in policymaking and (2) establishing new areas in which political elites gather consensus, develop alliances, and offer privileges to their supporters. These two elements are critical because when the social contract is framed in such a way that the two elements are tolerated and perhaps even welcomed for a long time, Bismarck gets replaced by Beveridge, and three types of transaction costs make backpedaling all but impossible: the costs of agreeing on a new and more transparent redistributive covenant; the costs of dealing with the social tensions provoked by rent-seeking groups whose privileges are threatened; and the costs of interacting with a poor judicial system. The first two are obvious. As noted previously, state provision and administration of health-care services are accompanied

12. I refer here to John Rawls's initial proposal that the state should equalize money incomes across the population without interfering with the structures of consumption and production.

13. See Scott 2001, 25–29, for a list of the traditional market failures that are assumed to justify government intervention in the health-care sector. The claim in favor of entrusting the state with producing merit goods is also weak: those who advocate Rawlsian redistribution confined to such goods can simply hand out nontransferable vouchers rather than cash.

by the rise of powerful interest groups that gradually transform their status into sets of privileges. Poor skills and shirking are the most visible consequences, along with these groups' unwillingness to operate in a competitive environment. Furthermore, this system offers political elites opportunities to consolidate and possibly to expand their power—for example, by expanding the bureaucracy. None of these groups will give in without a fight. With regard to the third type of cost, citizens face a simple alternative when choosing between a privately operated system (perhaps complemented by transparent income transfers) and a state-operated system. 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. The better choice between these two alternatives is not obvious. A snail-paced counterpart who eventually gives in to most of 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.

From the Illusion of Bureaucratic Wisdom to Managed Competition and Targeted Redistribution

If my analysis is correct, the future of the traditional European welfare state is relatively easy to characterize. On the 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 in regard to health care, significant results will follow only if demand is severely restrained by rationing or by mimicking market pricing. In fact, in several cases managed competition has rather ironically become a euphemism for these very measures.[14] 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 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 especially burdensome where socialist schemes prevail and can easily block most reforms. For example, 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.

14. A telling example is the proposal to reform the British National Health Service that David Cameron's government put forward in January 2011. According to this plan, health care would still be supplied free of charge, but it would be provided by consortiums of doctors that would be allotted a budget and a price list with which the buyers (that is, 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 available.

To summarize, Bismarckian countries can move their national health-care scheme toward a "targeted redistribution" pattern with little trouble. In their case, privatization is clearly a feasible option because the rent-seeking elements are neither too strong nor too harmful. True, public opinion can hardly see the necessity of privatization, but that perception is another story. By contrast, in Beveridgean countries, the real beneficiaries of the system are first and foremost the program administrators and the politicians, followed by a significant portion of the providers and the suppliers, 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.

Those who have an interest in galvanizing against these coalitions unfortunately hesitate—and for good reason: they fear the transaction costs mentioned earlier, and they sensibly mistrust politicians' assurances about the benefits (lower tax rates or offsetting income transfers). People certainly 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 that includes a set health-care package more or less independent of the subscribers' incomes. Politicians are their counterparts and have an interest in ensuring that the package is as generous as financially possible and in relieving the citizens of several irksome responsibilities: deciding how much consumption should be sacrificed in order to pay for health care; choosing an adequate provider; comparing prices; engaging in preventive care; and taking doctors to court should one feel duped and enduring the pain of coping with an ineffective judicial system. In short, people have accepted the premise that health is "too important" for private individuals to decide; thus, they have focused on seeking 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 perhaps to accept some restrictions, but they do not wish to abandon that system and thus incur the cost of fighting rather daunting rent-seeking coalitions. Appreciating this situation helps us to understand why, despite the many demands for reforms, improvements, and rationalization, few citizens favor drastic changes.

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, I believe that unless a radical change in attitudes is brought about, the answer is indeed in the negative. Individuals in paternalistic contexts do not see the need for change because in those countries public finance is still under control. However, 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,[15] and they eventually back down when confronting the risk of reducing the rent-seeking structure. The public does seem to realize that stabilizing government indebtedness without freezing public expenditure is going to be difficult. Nonetheless, the economic incentives to intervene in state health-care systems 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. State pensions are considered a much more promising target for cost-cutting exercises.[16]

Yet the environment is not totally static. The crisis of the welfare state is manifest, and its primary justification—the myth of social justice—is becoming subject to 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.

Justice, Equality, and the Aristotelian Perspective

According to the most discriminating advocates of a compulsory, universal, state-financed health-care system, this arrangement gains its legitimacy because of its intrinsic morality.[17] 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"—that is, with one's inner drive and right to discover and realize one's 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 condition 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

15. The evidence for the EU15 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 having Beveridge-type systems) at the low end and Germany and France (both having Bismarck-type systems) at the top end.

16. Intervention in this area may also have positive effects on growth (Eberstadt and Groth 2007). As long as individuals retire at a constant age, but their lives lengthen, their burden on social care (including health care) increases. By contrast, if the "old" cohorts were allowed to stay active, health care might become a profitable social investment rather than a drag on collective consumption and a burden to taxpayers.

17. See, for example, Ruger 2004 and 2007 for clear statements of this thesis and references to the relevant literature.

through which the individual discovers and possibly realizes his inner nature. Instead, it defines 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 all members of the community obtain these outcomes (Sen 1999). This characterization is the essence of (social) justice and (social) equality. Health and socialist health care fall squarely within this perspective because sick people would find it difficult (or more difficult) to flourish given that their illness restrains their actions and that the necessary treatments, absent state intervention, would absorb resources that otherwise would be devoted to pursuing the outcomes they would like to secure (social flourishing). Hence, according to this view, state intervention in health matters, even though it may be inefficient and even disappointing, cannot be denied its role. Government regulation and production in this field may be subject to changes and improvements, but they cannot be removed from the center of the stage. However simple and demagogically attractive these ideas might appear, though, they are conceptually flawed and operationally ineffective.

The operational weaknesses stem from the fact that social actors in a world of scarcity choose among different desirable ways of enhancing their intellectual budding and growth. This choice is actually what flourishing is about—the individual discovery and development of one's self. One person might focus on health, another might want better education, a third might require a guaranteed income and enough leisure to engage in a life of meditation free from earthly worries and troubles. In short, 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 example, denying individuals the freedom to choose and depriving them of their earned income are surely among such ways. Yet these actions are the very essence of regulation and taxation. Of course, deferring to the political process—public reasoning and democratic decision making, as Jennifer Ruger (2004) suggests—only adds to the confusion. As previously noted, the enforcement of social justice, rather than enhancing conscious choice and individual responsibility, 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, the instruments to obtain social justice favor the creation of privileges rather than individual fulfillment.

From the conceptual vantage point, the Aristotelian interpretation put forward by the supporters of social flourishing overlooks the point 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 (i.e., ownership of one's self and sacredness of property rights):[18] it does not consist of a set of positive rights, nor

18. Wright 2000 offers a critical survey of the Aristotelian natural-law tradition spanning Aristotle, Aquinas, Kant, and Finnis.

is it a list of desirable goods and services to which a society should grant free access. That such sets and lists are prepared by enlightened elites or agreed on 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 take place only amid bundles of positive rights whose corresponding obligations fall on 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, which are punctuated by luck and accidents, driven by a subjective evaluation of the outcomes, and characterized by the material rewards and punishments the market process generates. 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 because *eudaimonia* is definitely an individual perception and the destination of an individual journey. 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 individual natures and to realize their individual potentials.

Justice and Human Dignity

The upshot of the foregoing discussion is that in the Aristotelian world the individual is indeed a social and political animal because 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 state's role is to ensure that individuals 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 recipe amounts to the well-known negative notion of justice: "just" is the opposite of "unjust," and "unjust" is whatever 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 oneself, of choosing according to one's own inclination, no matter whether other people believe in priorities dictated by alleged metaprinciples (such as religion or race) or by political processes (such as majority or supermajority decision making). People may benefit from advice and guidance, but the decision to follow or to reject guidance remains each individual's own responsibility. Thus, justice cannot exist without human dignity, which cannot exist without personal responsibility. By denying the freedom to choose, state intervention offends both justice and human dignity.

In particular, as a result of taxation, regulation, and the production of merit goods, flourishing has become a social endeavor rather than a course of individual discovery; the rise of rent-seeking coalitions has emptied the notion of social equality; and compulsory redistribution has violated the principle of equality broadly understood because compulsory redistribution implies that human dignity is less and less important as one becomes richer. State intervention implies that choice has been removed from the individual and that individual responsibility necessarily has been 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, which is 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 metaprinciple 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 objectives, such as a particular living standard, a minimum GDP per capita, or other similar variables. The principles of justice and human dignity in themselves are ends or 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 against our right to pursue virtue. Those who advocate state intervention in the realm of health, therefore, cannot appeal to the notions of justice or human dignity because socialist health care is in fact manifestly inconsistent with those very notions and is thus immoral.[19]

Where Do We Go from Here?

As noted earlier, it is unlikely that state intervention in the health industry will be diminished because of financial stringency. It will be capped and gradually reformed, but the health budget per se is unlikely to cause major turnarounds. Nonetheless, 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 might transform resentment into

19. 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 chosen means of flourishing. However, the burden of proof remains on the advocates of paternalism, who must show that flourishing is hampered by some kind of genetic bias resilient to man's evolutionary history and that an appeal to "genetic mistakes" is not simply a way of asking for subsidies after one has gambled and lost.

illegitimacy and whether this change might be sparked in or perhaps by the health-care industry.

A social arrangement loses legitimacy when it comes to be generally perceived as unjust, and hence the search for alternative, fairer solutions becomes more active. Therefore, in order to proceed with our inquiry, we should investigate how people perceive the notion of justice and what drives its dynamics.

In a wide-ranging survey on the perception of justice, Paul Robinson, Robert Kurzba, and Owen Jones (2007) have clearly and persuasively shown that individuals are genetically programmed to develop a sense of justice from the early stages of their lives. This development may be defined as "core justice": our sense of right and wrong comes from our genes and originates in an evolutionary process that spans millennia. But there is also a second layer of moral assessments that is heavily influenced by the environment and gives substance to the notion of "consequentialist justice." In this layer, the individual understands and accepts an institutional context that has proved to be stable, diffusing social tensions and fostering desirable opportunities for interaction. Physical aggression and armed robbery are considered to be violations of core justice, for example, whereas some forms of opportunism (holding out, tax evasion, and some forms of free riding) are seen as offenses against consequentialist justice. To be fair, it is not always easy to draw the line. When consequentialist justice is consolidated 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. However, some elements of core justice may be sidestepped when they are manifestly conducive to conflicts and economic decline, and over time some ethical principles may be 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 European-style welfare states in past decades are too recent to have become part of core justice. Because these principles are not embedded in our genetic pool, they can be revised or simply rejected relatively rapidly. Does this potential for change exist in the provision of health care?

Charity to other members of the community, especially to sick people, historically has been considered for the most part as a moral duty of the individual. Yet it has probably never been an element of core justice to be enforced at all costs. Mean behavior surely has frequently provoked moral disapproval, but until the beginning of the twentieth 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 come to be seen as (consequentially) just

because it is regarded as part and parcel of the democratic system and the social contract it is supposed to embody and express. 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 had to foot the bill. Today, however, the balance between the core and the consequentialist components of justice seems to have become more shaky. As long as we agree that government intervention in health matters is justified by consequentialist justice, state-managed health care loses at least part of its legitimacy when it becomes apparent that such intervention does not meet people's expectations. Therefore, if the conflict with the shared notion of core justice sharpens, the underlying institutional context will be perceived as obsolete and will eventually invite radical reform.

At present, the case for consequentially just state-provided health care may be facing a crisis. True, most people would not articulate their apprehension in terms of justice and are 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 the substitute for democracy—violence (or the threat thereof) made legal by majority consensus—is not always regarded as just in the core sense. Disenchantment and unease follow: people realize that income redistribution is not equivalent to wealth sharing and that rent seeking satisfies the requirements of neither consequentialist justice nor core justice. 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 upshot come fully to pass, looking for alternatives would no longer be understood as a betrayal of an alleged social contract, but rather as the search for new ways of conceiving of legitimate social arrangements and of reducing the gap between the moral relativism prompted by expediency and our core sense of justice. To be sure, health remains a special area in the assessment of one's moral obligations toward the other members of society, but the justification for a socialist solution definitely loses the appeal it had in the beginning. In sum, social concerns about human flourishing may 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 important, created tensions with our (sleeping) sense of core justice.

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 tax revenues. 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 us 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 hence economic growth.[20] Public expenditure is indeed problematic, but slow economic growth and stagnation are worse. As history confirms, to reduce the expenditure/GDP ratio, expanding the denominator is more important than squeezing the numerator. In short, hope of avoiding bankruptcy rests with the economy's ability to grow, which requires a new notion of fairness, extensive deregulation, deep reform of most tax systems, and the drastic reduction of the incumbent rent-seeking structures. Future redistribution will not have to reproduce hypothetical choices made behind a veil of uncertainty but instead will help people to bridge the gap between their starting points and a set of minimal socially shared goals (the essence of targeted redistribution). Despite the health-care industry's weight, therefore, the cost of government intervention is not the main source of problems for our welfare systems. True, in a crunch, 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 favored, opting out of mandatory health contracts encouraged, and the size of state-managed health-care supply reduced following the decline in demand. Yet, as I have argued, this scenario is unlikely to arise because transition is barred by the strong and deep rent-seeking structures that today characterize most health systems built in accordance with Lord Beveridge's model and those that have absorbed some of its elements. Large, politically powerful groups of privileged individuals ensure that privatization remains politically difficult to obtain, and high transaction costs and limited trust in the judiciary keep the pressure for a transition low. These conditions explain not only why the Beveridgean world is not sustainable, but also why it will not be abandoned unless people change their perception of the role of the state or the most detrimental features of rent seeking come to be deemed intrinsically immoral and are thus delegitimized.

Transition to light forms of paternalism or to an outright free-market arrangement remains problematic as long as the status quo can draw support from consequentialist justice. Generic claims in favor of efficiency and public finances until recently have not been compelling enough to lead to 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 would put them on the winning or the losing side. These large groups have now come to realize that transition would make society

20. 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 diminish the state.

better off in the medium and long run. Yet as populations have grown older, the relevant time horizon for the median individual has become shorter, and the prospect of taking a chance and suffering the cost of transition has grown less exciting: the temptation to free-ride on the next generation (that will inherit our debt) has proved all but irresistible. This course of action is of course both rational and hypocritical. Sad to say, by arguing in favor 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 has also seriously hampered our prospects for growth, and today's financial stringencies may change our perspective once again. If so, the current consequentialist connotation of social justice may crumble. In that event, large chunks of the welfare state, including government production of health-care services, may collapse, and the notions of human dignity and individual responsibility may regain center stage in the ongoing life of our civilization.

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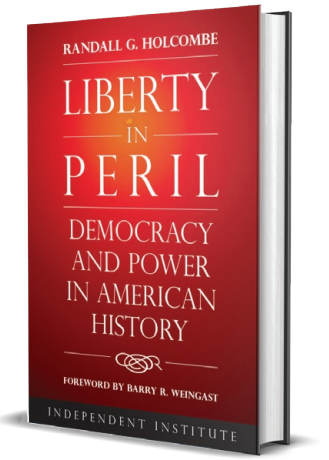

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