B18, September 30, 2016

May a Government Mandate more Extensive Health Insurance than Citizens Want for Themselves?[1]

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"What do you say to Mark and Lucinda in my district who had a plan, they liked it, it was affordable, but it is being terminated [because it is not sufficiently comprehensive to meet the requirements of the Affordable Care Act]? It was what they wanted and I will remind you: some people like to drive a Ford, not a Ferrari. Some people like to drink out of a Red Solo cup, not out of crystal. You are taking away their choice."

Rep. Marsha Blackburn (Republican) to US Secretary of Health Kathleen Sebelius, House Hearing on Obamacare, 30 October 2013

[1] This paper was presented at Georgetown University, the Hebrew University of Jerusalem, and the Oxford Studies in Political Philosophy Conference at the Universitat Pompeu Fabra. I am grateful to those present and to Paul Bou-Habib, Luc Bovens, Kasper Lippert-Rasmussen, Colin Macleod, Joseph Mazor, Michael Otsuka, Tom Parr, Gopal Sreenivasan, Peter Vallentyne, and Andrew Williams for comments and discussion. I also thank the U.S. National Institutes of Health for a Visiting Scholarship. The opinions expressed are the view of the author. They do not represent any position or policy of the U.S. National Institutes of Health, the Public Health Service, or the Department of Health and Human Services.

Introduction

In most developed and many developing countries, governments require citizens to be insured for a minimum set of health care interventions. They typically do so through some combination of the following mechanisms: (i) the provision of tax-financed care (as, for example, the Universal Health Scheme does for informal sector workers in Thailand and Medicare does for the elderly in the US); and (ii) mandating the purchase of at least a minimum package of insurance from a social insurance fund (as, for example, Thailand does for formal sector workers) or from a private provider (as the US Affordable Care Act does for the non-poor and non-elderly).

In this paper, I shall address two questions about such policies. The first is, what, if anything, justifies the limitation they place on the freedom to spend one's fair share of resources as one sees fit? Consider, for example, the typical citizens invoked by Representative Blackburn. Suppose they have average incomes and modest current health risks, are prudent and adequately informed about the costs and benefits of various insurance packages on offer. Why should they not be permitted to spend the money they are required by the Affordable Care Act to spend on health insurance in whatever way they prefer, for example by purchasing cheaper, less comprehensive insurance and using the remaining funds for other purposes?

The second question is this: if mandatory insurance is justified, how should governments determine the content of the mandatory minimum package?

Various answers to these questions have been proposed, in part because tax-financed government provision and mandated coverage are complex arrangements that serve a variety of ends (see Daniels 2013 for a review). One such end is protection against the

consequences of imprudent risk-taking (Dworkin 1994, n3, 2000, p. 492n6; Bou-Habib 2006; Moncrieff 2013). Another is to fairly and efficiently cover the costs of the care that we are obligated to provide on humanitarian grounds, such as basic care for those in urgent need who could not afford to pay for such care out of pocket (Buchanan 1984; Bou-Habib 2006; Menzel 2012). In this paper, I shall not focus on these reasons for requiring coverage, important though they may be. Instead, I shall critically analyze the following well-known pair of liberal egalitarian answers for the case of prudent, adequately informed adults (Dworkin 1994, 2000, chap. 8, 2012; Braun 2012; Menzel 2012; Gibbard 1984 makes a similar argument on utilitarian grounds):

> **(i). Unfairly differential health risks and "adverse selection" in the insurance market together create a problem to which forced insurance is the solution.**
>
> People are at unfairly unequal health risk, because much ill health is due to genetic and environmental factors for which individuals should not be held responsible. Fairness therefore requires that the premiums of those who are at high risk should not differ much from the premiums of those who are at low risk. However, if each person could decide whether or not to insure themselves on these relatively equal terms, insurance would prove attractive principally to those with high risks, while many at low risk would choose not to insure themselves, because the assurance of affordable care would not be worth the cost to them. (This is known as adverse selection [Arrow 1963].) The resulting pool of voluntarily insured people would therefore disproportionately consist of high risk individuals. It would require unaffordably high premiums to cover this pool. To keep the premiums for those at high risk affordable, those at low risk must be required to enter the insurance pool.

(ii.) The mandated minimum package of services should be determined by the "representative prudent individual test" (RPIT).

A government should mandate the package that a representative prudent and adequately informed individual would wish to purchase for themselves if they were placed in fair conditions of choice with relevant information.

In this paper, I will argue that answer (i) is incomplete because we have additional, social egalitarian grounds to force people to buy health insurance. I shall also argue that answer (ii) is incorrect because it is insufficiently egalitarian. Rather than using the RPIT, we should design the mandatory package by appealing to a pluralistic egalitarian view, which cares about improving people's well-being, reducing unfair inequality, and maintaining egalitarian social relations.

My argument proceeds as follows. In Section 1, I offer a fuller explanation of proposed liberal egalitarian justifications for a mandate and for the RPIT.

In Section 2, I consider circumstances in which individuals face differential risks. I argue that under such circumstances, mandating the insurance that a representative prudent individual would purchase wrongly treats interpersonal trade-offs as if they were intrapersonal trade-offs and ignores unfair inequalities.

In Section 3, I consider circumstances in which all individuals are at equal risk and have equal purchasing power. Under such circumstances, the account I am criticizing holds that there is no reason for a mandate. I shall argue that this account fails to consider the social effects of universal health insurance. These social effects, I argue, have the character of public goods, whose provision is underprovided when individuals are free to make their insurance decisions independently. This gives us reason to mandate a different, and in

certain respects more extensive, minimum package than each such equally-situated, prudent individual would desire for themselves alone.

1. The argument for mandating the package of insurance desired by a representative prudent individual.

Against a backdrop of large social and economic inequalities, in a free market, health insurance would be unaffordable to the poorest, who could also not afford substantial out-of-pocket expenditures on health. If, as I shall assume, in contemporary societies the poorest are worse off than they would be in a just society, then a free market in health insurance would compound existing injustice by leaving the poor exposed to the greatest health risks (as well as the financial risks that attend ill health, such as out-of-pocket expenditure and income loss).

This problem alone, however, does not justify forced insurance for all. For it might be addressed through income transfers, through tax-financed care for the poorest only (such as Medicaid in the US), or through subsidized voluntary health insurance.

Instead, leading thinkers have argued that a mandated minimum of insurance is justified as the best solution to two other problems that would occur in a free market in health insurance (Gibbard 1984; Dworkin 1994, 2000, chap. 8, 2012; Braun 2012; Menzel 2012; WHO 2014, forthcoming).

The first problem is that people who are at low risk in a given period (e.g. the young and healthy) would be charged relatively little for insurance, while those who are at high risk (e.g. the old or ill) would be charged a great deal. Assuming that a large proportion of differential health risks are not the result of free, adequately informed choice under fair

circumstances but are rather instances of bad brute luck, this would add financial burdens to the disadvantage of being at high health risk. Moreover, many of the most vulnerable would be priced out of insurance coverage and, therefore, be able to purchase needed care, if at all, only at very high personal cost.

To avoid such unfair premium differentiation according to people's personal risk profile, in a health insurance market, insurers must therefore be obligated to take anyone who applies for health insurance at a premium that is relatively independent of the applicant's personal risk profile. (This is known as "community rating.")

Such community rating leads to the second problem. Suppose that firms were to set the premium for everyone (regardless of their pre-existing health risks) at a price that would cover the average person's health expenditure. At this premium, insurance would be least attractive to people who believe themselves to have lower-than-average expected need for health services and most attractive to people with a higher-than-average expected need for health services. Since many people are aware of their (approximate) risk profile, those who would enroll would tend to have a disproportionately high risk (Arrow 1963). To cover the costs of this high-risk pool, firms would have to charge higher premiums to the enrolled population. But doing so would, at the margin, cause those with the lowest risks to drop out of the pool, since they would then regard insurance as too expensive relative to their personal risk profile. This would further worsen the risk profile of the enrolled population, meaning that the premium would have to be raised again, leading to a so-called "death spiral" of an escalating premium and a worsening risk pool. Without intervention, this adverse selection mechanism may destroy the insurance market despite there being potential gains from trade (Akerlof 1970).

In theory, these problems might be addressed by pairing community rating with extensive subsidies for voluntary enrolment to counteract adverse selection. However, the experience of countries at all levels of development suggests that voluntary enrolment generally does not adequately solve them (Carrin and James 2005; Lagomarsino *et al*. 2012; Cotlear *et al.* 2015). By contrast, together, community rating and mandatory enrolment achieve both fair cost-sharing between those at low and high risk and a solution to the adverse selection problem.

The compulsion of those who would rather not now enroll because they are currently at low risk is not merely a case of forced transfers to others who are less well off. Presumably, many people who are currently at low risk want health insurance available to them at reasonable cost when their risks become high (such as later in life, or when they develop a need for expensive care). Due to the aforementioned death spiral, such insurance might not then be available to them at affordable cost if enrolment were voluntary. Many may therefore prefer, on their own behalf, that everyone is required to be insured when they are at low risk in order to guarantee that there is a well-functioning insurance market with reasonably priced coverage when their expected need for costly care is high. Mandatory payments may be justified to them as an efficient way to get something they would be unable to get if they were free to make insurance decisions on their own (Braun 2012; Menzel 2012).

Naturally, a mandate needs to be paired with income-dependent subsidies to avoid unfairly burdening the poor. (A tax-financed government health system can, of course, also collect higher payments from those who earn more.) A mandate of this kind redistributes resources from rich to poor and from the young and healthy to the elderly and infirm. Like many

solidaristic arrangements, it has a mixed justification. In part, it appeals to a pluralist egalitarian conception of justice that cares about reducing inequality and promoting the general welfare, and which therefore favors policies that improve the lot of those who are unfairly disadvantaged economically or in terms of health prospects. In part, it appeals to each person's self-interest in establishing an institution that serves this interest better than uncoordinated individual choices would.

I now turn to the question how one ought to draw the boundaries of the package of mandated care. To many, the following line of reasoning has seemed compelling (Gibbard 1984; Dworkin 1994, sec. 2; 2000, ch. 8; Menzel 2012, p. 591; Kurtulmus 2012). Suppose that each current member of our society would rationally pursue their current preferences, had a fair share of resources, had the average health risks of people in our society, could enter into a lifetime insurance policy (so that they could not have to renew insurance after developing an illness or health risks later in life) and was well-informed about the prospective benefits and costs to them of each feasible package of health services. In such circumstances, there would be no need to require community rating, since everyone's risks would be identical at the moment the insurance contract was signed. For the same reason, there would be no need to step in to prevent adverse selection. Moreover, there would be no other reasons of justice to interfere with individuals' choices regarding health insurance—the resulting pattern of insurance would be fully just. We should use this idealization of our society as a reference point for mandatory insurance in our actual, unjust circumstances. In the idealized circumstances, what each individual would want for themselves would depend on their preferences. Because these would differ, individuals would therefore want different insurance plans—some would desire an extensive package, others a small one. We cannot replicate this diversity of individually-tailored insurance plans

in our society for many reasons, including the adverse selection problem outlined. But we should approximate it by determining the content of the required insurance package as follows.

> **RPIT:** We should mandate the lifetime package of insurance that a representative prudent individual with a fair share of resources would want for themselves if (a) their self-regarding preferences (including their risk attitudes) were those of a typical person in our society; (b) they faced the average lifetime health risks in our society; (c) they knew the potential costs and benefits to them of the package; and (d) their risks, costs and benefits were calculated under the assumption that the package selected would become the required minimum for all.[2]

The fundamental logic of the view under consideration, then, is this. The market for health insurance requires intervention because of unjust inequalities in financial resources and health prospects. Due to adverse selection, these injustices are most efficiently addressed through some form of forced insurance. In determining the content of the mandatory minimum package, we should ask what a prudent representative person in our society would want on their own behalf to be made mandatory for all in a society that is like ours in terms of health risks, costs and benefits, but with the aforementioned injustices removed.

[2] While it differs from their individual proposals in some respects, this formulation of and motivation for the RPIT picks out the common elements in proposals by Gibbard, Dworkin, Menzel, and Kurtulmus that are relevant to our purposes here. The formulation employed avoids some of the problems with Dworkin's (1994, 2000) version of the RPIT raised by Macleod (1998, pp. 92-6) and Kurtulmus (2012).

When paired with adequate subsidies to the poor, enforcing the purchase of this basic package is a good way to make society conform more closely to the just ideal. In the remainder of this paper, I shall raise objections to this view and propose revisions to it.

2. Differential risks and the separateness of persons

I shall begin by arguing that the RPIT needs to be discarded. To illustrate its problems, consider the following Differential Prospects Case. Suppose that a three-person society of Misery, Fortune and Avy is about to implement a new mandatory package. Misery has recently been diagnosed with a serious health condition, so her lifetime need for health care is certain to be great. Fortune, by contrast, is certain to possess excellent lifetime health and have little need for health care.[3] Avy has average prospects: she is in good health now, but will end up in either the same situation as Misery or the same situation as Fortune, with each possibility being equally likely. The three feasible policies are: Small (a low-cost package with limited coverage), Medium (a moderately costly package of middling coverage), and Large (a very costly, but also very comprehensive package). So that we have a concrete measure of prudential interests in terms of which we can assess these packages, I shall assume that prudential interest is identical to well-being and is measured as follows, in line with orthodox decision theory. A first alternative has higher expected well-being for a person than a second alternative just in case the first would be strictly preferred for this

[3] Of course, in reality, no adult enjoys such certainty, but we grant Fortune knowledge of her unusual fortune for the sake of a simplifying idealization of the situation of individuals who are known to have very good health prospects.

person's sake after rational, calm deliberation with all pertinent information while considering their self-interest only. Two alternatives yield equal expected well-being just in case such deliberation would yield indifference between them.[4] (I shall comment below on what would happen if one instead used a measure of well-being derived from a rival decision theory.) The impacts of these three insurance packages on each person's well-being are represented in Table 1.

Table 1. Lifetime well-being for three insurance packages in the Differential Prospects Case (Misery's and Fortune's well-being is certain under each policy; the well-being listed for Avy is her expected well-being).

Individual Policy	Misery	Avy	Fortune
Small	35	59.5	84
Medium	40	60	80
Large	44	59.5	75

[4] I follow Gibbard (1984) in assuming this measure, which draws on idealized preferences which respect the von Neumann-Morgenstern axioms. This measure does not presuppose any particular view on what well-being consists in. One might maintain that well-being consists of something other than preference satisfaction and hold that the specified idealized preferences fully track the magnitude of this other thing (Otsuka and Voorhoeve 2009, pp. 172-3n3).

In this case, by construction, Avy's prospects are equally good under Small and Large. The RPIT is therefore indifferent between these packages. Moreover, her prospects are most advanced by the choice of Medium. Since Avy is the representative individual, the RPIT therefore requires us to mandate this package.

In the way it arrives at these judgments, this test makes three related, but distinct errors (Nagel 1970, pp. 132-42; Rawls 1999, secs. 5 and 39; Roemer 1985; Otsuka and Voorhoeve forthcoming).[5] The first error is its insensitivity to the presence or absence of prudential justifications. Choosing Medium can be prudentially justified to Avy. Even if she later ends up needing more health care than this package gives her access to, we could defend a choice of this package as having been in her best interests, given the information available at the time the decision had to be made. By contrast, no such prudential justification is available to either Misery or Fortune for the choice of Medium. To focus on the worst off in particular (because it is typically especially challenging to justify arrangements to them): one cannot say to Misery, "I chose Medium for your sake." This difference makes a choice of Medium easier to justify to Avy than to Misery. It would also make Medium easier to justify in a different society in which, at the moment of policy choice, everyone is in Avy's situation—which involves a 50-50 chance of ending up miserable or fortunate—than in our supposed society in which some are certainly in Misery's situation and others are certainly in Fortune's. The RPIT, however, does not register these differences in justifiability: it would endorse Medium in both a society that consisted entirely of Avys for the same reason that it requires it in a society of Misery, Avy and Fortune—viz., that it is in Avy's prudential interest.

[5] See Otsuka (2012) for a demonstration that these three errors are logically independent.

The second objection to the RPIT is that it is insensitive to the fact that some will be better off than others. When one evaluates a policy solely on the basis of Avy's prudential interests (that is, by their expected well-being for her), one pays attention to how she will fare under that policy in each of her potential futures, but one does not consider it as in itself bad that in one potential future she would be better off than she would be in another potential future. Small and Large are equally good prospects for Avy because they yield the same expected well-being, even though the gap between her worst and best potential outcome under Small is greater than the gap between her worst and best potential outcome under Large. The RPIT takes the same attitude to the fates of co-existing separate people as it takes to the equally likely potential futures of a single person. It therefore is indifferent to the inequality between two coexisting, separate people (Misery and Fortune), just as it is indifferent between two mutually exclusive futures of the same person (Avy). For the RPIT, Small and Large are equally good policies, even though the former contains more interpersonal inequality than the latter. This lack of concern for how some fare compared to others is not merely substantively mistaken—it is also inconsistent with the aversion to unfair inequality that motivates the account. The RPIT does not, therefore, fit well within a liberal egalitarian theory of health care justice.

The third mistake is to fail to recognize individuals' competing interests. When different people's interests conflict, a person's claim in favor of a policy depends in part on how badly off this person is compared to others whose claims compete with theirs. By way of illustration, in a pairwise choice between Small and Large, Misery could pose the following rhetorical question (Otsuka and Voorhoeve 2009, pp. 183-4):

> "How could you choose to forgo a very substantial benefit to a worse off person to instead provide an equally large benefit to someone else who will, in any case, be much better off?"

Moreover, in a pairwise comparison of Medium and Large, the following complaint on Misery's behalf against a choice of Medium would be almost as forceful, and, I submit, equally unanswerable:

> "How could you choose to forgo a substantial benefit to a worse off person to instead provide what is only a somewhat larger benefit to someone else [Fortune] who will be much better off and a small improvement in the prospects of another [Avy] whose prospects are also far superior to those of the worst off?"

No such questions arise when we compare these policies solely in terms of their impact on Avy's prospects—one could not complain, on behalf of the unlucky possible future of Avy's, that by choosing Medium (rather than Large) one would be failing to benefit them in order to provide a somewhat larger benefit to a different person. By focusing solely on Avy's prospects, the RPIT therefore fails to recognize considerations that arise only in interpersonal trade-offs.

My argument so far has assumed a measure of well-being that relies on standard decision theory. A familiar objection to this theory (and my related assumption that prudence requires maximizing expected well-being) is that one should be permitted to overweight relatively worse possible outcomes. A well-known alternative to standard decision theory indeed permits decision-makers to do so (Quiggin 1993; Buchak 2013). In evaluating a risky alternative for a person's sake, it makes the weight that one assigns to a possible outcome depend on both its probability and its rank among possible outcomes and permits giving a

lower-ranked possible outcome more weight than its probability alone would warrant. It is therefore worth noting that my central objections to the RPIT's reasoning would still apply if one instead used this "rank-dependent" decision theory. (One would, however, need to alter the simple numerical example I have used in order to illustrate my objections.) First, consider prudential justification. The RPIT would still choose which policy to apply to everyone by using the rank-dependent weighting of possible outcomes that would be appropriate to Avy's prudential perspective. It would therefore still fail to register the difference in the justifiability of the policy that was prudentially best for Avy between: (a) a society of Avys, to each of whom the policy can be prudentially justified, and (b) a society in which the policy also affects Misery and Fortune, to whom no such justification exists.

Second, consider aversion to inequality. Because it would permit giving more weight to lower-ranked possible outcomes of Avy's, a rank-dependent decision theory would permit aversion to inequality between the two people, Misery and Fortune, whose fates correspond to Avy's possible futures. However, it would still impose the same aversion to inequality between two mutually exclusive potential futures of a single person as it would to the inequality between two coexisting people. Since the former inequality is not unfair, while the latter is, the RPIT would still fail to respond appropriately to the badness of inequality.

Third, by using a form of weighting that is appropriate only to intrapersonal trade-offs to make interpersonal trade-offs, the RPIT would still not take seriously conflicts of interests between separate people.

In sum, whether we assume orthodox decision theory or a leading alternative, the heart of the problems with the RPIT remain. A pluralist egalitarian view, which gives weight to both

reducing inequality and promoting the general welfare, avoids these problems (Otsuka and Voorhoeve forthcoming). Appealing to such egalitarianism to design the package also makes for a consistent rationale, because it means that the very same value that motivates the mandate (that is, the elimination of unfair disadvantage) determines what is mandated.

This implies that in selecting the mandatory package, one should give greater weight than the RPIT does to the fate of those with worse prospects and outcomes. Such a package will tend to include more measures to prevent or alleviate illness among those with poor lifetime health than the RPIT would recommend, for the following reasons. Those with poorer lifetime health also generally have fewer financial resources and lower social status (Deaton 2003, 2013). Interventions that improve the lot of those with worse lifetime health will therefore tend to disproportionately benefit those who are worse off overall. Moreover, in a system in which premiums are income-dependent, such health interventions will disproportionately be paid for by the financially better off (who are also typically healthier). Indeed, insofar as greater coverage leads to greater transfers from the healthier and wealthier to the sicker and poorer, the proposed egalitarian criterion will lead to more comprehensive coverage. Such a scenario is captured by our simple example, in which, I submit, the Large package should be universally mandated on pluralist egalitarian grounds. However, it is important to note that such an egalitarian criterion would also give less weight than the RPIT to the interests of the better off. It might therefore also exclude some preventative or curative interventions that the RPIT would have us include.[6] Such excluded interventions would be those that both disproportionately benefited the better off and

[6] I am grateful to Kasper Lippert-Rasmussen and Peter Vallentyne for drawing my attention to this point.

imposed a substantial burden on the worse off, either in direct financial terms or in terms of other improvements to their lives (e.g. in education, housing or environmental quality) that could be made with the resources in question. The practical upshot is likely to be a package that is substantially different from, and in certain respects considerably more comprehensive than, the package recommended by the RPIT.

3. The case of identical risks: From individual to social concerns

I shall now argue that the grounds for a mandate extend beyond the need to solve the problems created by a combination of unfair differential risks and adverse selection. I shall therefore focus on situations in which these problems are absent because everyone's situation, including their financial resources and health prospects, is identical at the moment of decision.

By way of illustration, consider the following Identical Prospects Case. Suppose a large society consists only of adult Avys, each of whom, as above, faces a 50-50 gamble between a serious illness and a long, healthy life. Also suppose that it is known that precisely half of them will end up in either position. As in our earlier discussion, everyone is prudent and is well-informed of whatever risks he faces. The government can either leave everyone free to choose between the aforementioned three packages, or instead require everyone to purchase Large. Table 2 represents, for each insurance package, the prospects of each person and the distribution of final well-being in the population that would result if everyone had this package of insurance.

Table 2. Individual prospects and the distribution of outcomes for three insurance packages in the Identical Prospects Case

Individual Package	Each person's expected well-being	Distribution of final well-being in the population if everyone had the package
Small	59.5	Half at 35 Half at 84
Medium	60	Half at 40 Half at 80
Large	59.5	Half at 44 Half at 75

Given our assumptions, if each person had a free choice between these insurance packages and acted independently on their own behalf, each person would purchase Medium, because this is what maximizes their expected well-being. This will lead to substantially more outcome inequality than would arise if everyone were instead required to purchase Large. This inequality notwithstanding, in a case such as this, the account I have been criticizing holds that we have no reason to mandate insurance. In Ronald Dworkin's words:

> "whatever this … community actually spends on health care [as the result of people's free choices from a position of equality] is the morally appropriate amount for it to spend: it could not be criticized, on grounds of justice, for spending either too much or too little" (2000, pp. 312-3).

There appear to be several good reasons for Dworkin's conclusion. First, leaving people the choice between these three packages respects their freedom to use their fair share of

resources as they see fit; by contrast, mandating Large in order to lessen outcome inequality would infringe this freedom and their autonomy.

Second, given our assumptions, each will use this freedom to make what is, given the risks they face, the prudentially best decision for themselves. Concern for the well-being of each person, taken separately, should therefore motivate us to endorse each person's choice; it also counts against mandating Large.

Third, it appears that brute luck egalitarianism does not give us grounds to object to the difference in outcome inequality between Medium and Large. As I shall understand the brute luck egalitarian view, it objects to unchosen inequalities because they are unfair. It also holds that inequalities that are due to competent, free and informed choice against an equal background need not be unfair (see, e.g., Cohen 1989; Arneson 1989, 1997; Temkin 2001). In the Identical Prospects Case, the increase in outcome inequality between Medium and Large would be entirely due to such choices. This increase in inequality would, of course, be due to luck, but this would not be brute luck, but rather what Dworkin (2000, p. 73) defines as "option luck": "a matter of how deliberate and calculated gambles turn out—whether someone gains or loses through accepting an isolated risk he or she should have anticipated and might have declined."[7] This means that an aversion to brute luck inequality

[7] There are well-known difficulties in adequately spelling out the distinction between brute luck and option luck (Vallentyne 2002, pp. 531-4). There are also powerful arguments that even inequalities due to differential option luck are objectionable because people cannot reasonably be held substantively responsible for them (Lippert-Rasmussen 2001). I shall not engage with these challenges to the concept, since I shall argue, below, that even a

per se would not give us reason to favor a situation in which everyone chooses Medium over a situation in which Large is mandated.

Still, it does not follow that a brute luck egalitarian must countenance the outcome inequality that results from people's choices in this case. By itself, an aversion to brute luck inequality implies nothing about what kinds of choice-based inequalities one should permit (or favor) among people who face equal opportunities. Brute luck egalitarians must therefore rely on distinct principles of substantive responsibility to decide which choice-based inequalities to countenance (Olsaretti 2009; Stemplowska 2009). One such principle is that when there are no brute luck inequalities or market failures to correct, one ought to allow adequately-informed, rational people to freely contract (Dworkin 2000, ch. 2). Another such principle, advanced by Peter Vallentyne (2002, pp. 551-2), focuses on the value of people's opportunity sets. Vallentyne proposes that when, under conditions of equal opportunity, we must decide whether individuals should face a set of choices that will generate inequality, we should ask whether it would yield greater prudential value (higher expected well-being) for each person to face the inequality-generating choices or whether it would be more prudentially valuable for them to have the choice and its concomitant inequality removed. Since, in our case, individuals are assumed to choose what has higher prudential value for them, this principle favors leaving everyone a free choice in the Identical Prospects Case. In sum, both Dworkin's freedom-based and Vallentyne's value-based principles of responsibility appear to countenance the inequality that is due to choice in this case.

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responsibility-sensitive egalitarian who is generally willing to accept inequalities due to differential option luck should object to such inequalities in this case.

We have seen that respect for freedom and concern for people's well-being appear to favor leaving people at liberty to choose in this case, while the resultant increase in inequality (compared to mandating Large) can be put down to unobjectionable differential option luck. As Cass Sunstein puts these considerations in his work on risk regulation:

> "People should be sovereign over their own lives and government should respect individual choices about how to use limited resources (so long as these choices are informed). … If people are willing to pay [a certain amount] but no more to eliminate a risk [to themselves] …, then their [expected] welfare is decreased by asking them to pay more. […] [If] people are required to pay an amount for risk reduction that exceeds their willingness to pay, desirable redistribution will hardly result (2004, pp. 400-1 and p. 394; cf. Thompson 2016).

Despite its appeal, I shall now argue that this line of reasoning is mistaken. The first step towards seeing why is to notice that the risks that each is willing to run when they consider only their own fate may, when amalgamated across all individuals, have social effects that they rightly regard as undesirable.[8]

To give a simple example of this phenomenon, suppose that a group of twenty friends is considering going on a spectacular, but risky, mountain-bike ride. Though each individual's chance of injury is low, since they are in a large group and their risks of injury are independent, it is very likely that while most of them will be fine, at least one of them will

[8] My argument that a focus only on the individual impacts of a transaction omits consideration of its distributional and social impacts parallels Cohen's (1977) critique of Nozick's (1974) Wilt Chamberlain argument.

be injured. Suppose the risk to each individual, taken separately, is such that if they were travelling alone, each would rationally prefer to embark on the trip. Nonetheless, the knowledge that at least one of them is likely to be injured if they set out can prompt them to decide together to instead do something that is less spectacular but also less likely to lead to injury. The motivation for doing so would naturally be, I submit, both the prospect of painful fellow-feeling with an injured friend (their misfortune would predictably cast a pall on the trip) and a sense of camaraderie which makes them averse to outcome inequalities in the group.

Such a solidaristic ethos may exist (probably in a weaker form) within a nation, and may give each citizen reason to care not merely about their individual prospects, but also the inequality in outcomes that will result from these prospects, taken together. Applied to our Identical Prospects Case, each may find something to object to in the inequality that would result when everyone chooses Medium for themselves, because the misfortune of others sympathetically affects them and because they wish to limit inequalities in outcomes between fellow citizens.

Moreover, co-citizens have reasons beyond solidarity to object to inequalities. As social and political egalitarians have argued, inequalities are bad when and because they undermine individuals' ability to live as free citizens who can participate in social life and contribute to public decision-making on equal terms (Anderson 1999; Rawls 2001, sec. 39; O'Neill 2008; Fourie et al. 2015). In relation to health insurance and health care, this view raises five interrelated concerns (cf. Hausman 2015).

The first is the absence of domination in private life. This gives us special reason to avoid health states and financial circumstances that impair the ability to stand up for oneself,

because, for example, one has become highly dependent for needed care on the good will of more powerful others.

The second aspect of this ideal is an absence of domination in political life. We should, it holds, prevent social situations in which those who are less well off do not have their interests effectively represented because they face large obstacles to political participation or have become marginalized. This gives us reason to alleviate health states that tend to cause such obstacles and that lead to marginalization, such as severe impairments in mobility, in communication, or in mental health.

The third concern is to ensure the capacity to participate in public life with dignity—to be able to join in work, play, and general social interaction without shame or a sense of inferiority based on characteristics irrelevant to the status of citizen, such as ethnicity, economic circumstances or health. Alongside other factors (notably, social norm change), health insurance can contribute to securing this ability for all. The care to which it gives access can ensure that fewer people have conditions that generate a debilitating sense of shame or inferiority. Moreover, a system of insurance can be designed to limit the large disparities in health and wealth which give rise to norms of appearance and functioning that the less-well-off may struggle to meet.

The fourth concern is to ensure what Rawls (1999) referred to as the social bases of self-respect. Health insurance and health care can contribute to this through maintaining capacities central to people's sense of self-worth, including their independence, their ability to support themselves and their families, and their cognitive and physical functioning. Moreover, a guarantee of care can bolster the fragile sense of self-worth of the ill, because

it signals the value that others place on their well-being and on their functioning as a member of society.

The final social egalitarian concern is with ways in which inequalities may erode the attitudes required for social cooperation and may generate attitudes that undermine it. Large inequalities in health and income can generate a sense of inferiority among the less fortunate and arrogance among the fortunate (Tawney 1964, pp. 37-8). The less well off may also become resentful of others' advantages, leading them to prefer a situation in which the lives of the better off are diminished, even if this does not improve their own lot. In response, the better off may be inclined to jealously guard their relative advantage at a cost to themselves and others (Rawls 1999, pp. 467-8). One further possible effect is described by Adam Smith (1982, I.iii.1 [1790]). When the least well off are also very badly off, the better off tend to avoid interacting with them in order to prevent the painful sympathetic feelings that would be a natural consequence of being in their company. For their part, an uncomfortable awareness of others' desire to turn away from them causes the badly off to withdraw from society. Social co-operation—which requires a willingness to work with others to mutual benefit, to enter into reasoned discussion with them about fair social arrangements, and to abide by fair arrangements—is undermined by the attitudes that Tawney, Rawls and Smith identify. Insofar as it improves the fate of the least fortunate and lessens the gap between them and the rest of society, health insurance plays a part in preventing the spread of such problematic attitudes.

In sum, solidarity and social egalitarian ideals give citizens reason to evaluate mandatory insurance packages not merely on the basis of their effects on their self-interested

prospects, but also in terms of their effects on the wider distribution of well-being and on the quality of social relationships.

Of course, each individual's self-interested prospects should take into account the impact on their well-being of these social effects of a mandatory insurance package. These effects might be substantial. Living in a less unequal society might make one happier, more satisfied, or even—if virtue is easier to acquire and maintain in such a society—more able to achieve Aristotelian *eudaimonia*. But the importance of solidarity and social equality cannot be reduced to their prudential value. Solidarity gives one reason to improve the lot of the less well off for their sakes, and not merely one's own. Moreover, one has reason to pursue a society in which people can relate to one another as equal citizens because such a society involves relationships and attitudes which are in themselves good, and avoids the bads of domination, indignity, lack of self-respect, and unsociable attitudes. Even when the measure of each person's well-being takes into account these social effects, there can therefore be a tension between prudence and social egalitarianism.

In order to trace what follows from these observations for when the state can mandate health insurance, assume for the moment that for all citizens in the Identical Prospects Case, the gain in terms of solidaristic and social egalitarian value realized in a society in which everyone has the Large package of insurance outweighs the loss in prudential value. Wouldn't it follow that each if given the choice between Small, Medium and Large, each would voluntarily purchase Large? No. The reason is that the solidaristic and social egalitarian goods we have been considering possess two characteristics of public goods. The first is non-rivalry: one person's enjoyment of an egalitarian environment does not impair others' access to it. The second is non-excludability: one partakes in many (though perhaps

not all) of the goods of a society of equals whether or not one has "done one's bit" by purchasing Large. Together, non-rivalry and non-excludability create a familiar problem in generating the good of an egalitarian environment through purely voluntary individualistic action. The expected self-interested benefits of Medium over Large are notable, while the expected social effects of one individual purchasing Medium rather than Large are miniscule. This gives each person an incentive to purchase Medium when they face the decision on their own, even if they would (when considering both self-interest and their social egalitarian ideals) prefer a situation in which Large was purchased universally to one in which everyone purchases Medium. There is, then, a collective action problem. Each citizen, we have assumed, cares about securing a society of equals. But no one has the incentive to do their bit; nor can anyone be assured that doing their bit will achieve much of substance.

As with collective action problems generally, one solution is to restrict choice, and mandate Large. Especially in a numerous society, such a mandate may be the most efficient solution and may therefore be favored by each member of the population over less restrictive alternatives, such as legally permitting choice but establishing strong social norms in favor of purchasing Large. If so, then we can assume that each would approve of a law that required all to contribute to establishing a society of equals by purchasing Large.

It is noteworthy that under these circumstances, we do not have a wrenching conflict of values, with on one side, the reasons permitting free choice enumerated at the start of this section—respect for freedom and the importance of giving people prudentially valuable options—and, on the other, solidarity and social egalitarian concerns. First, since everyone gladly consents to the restriction of their liberty, the mandate does not violate their autonomy. Second, each is, by assumption, happy to suffer a small loss in their expected

well-being for the sake of acting collectively to improve the lot of whoever ends up worst off and for the sake of social equality. It seems right that a government should side with its citizens in balancing prudential concern for each citizen against these other values.

Third, consider again the argument that the extra outcome inequality that results from people's individual choice between insurance packages is unobjectionable option luck both because: (a) when people are equally situated and there are no market failures, egalitarians should countenance inequalities that arise from free contracting (Dworkin 2000); and (b) leaving people this choice ensures that each has the most prudentially valuable equal opportunity set they could have (Vallentyne 2002). This argument is on shaky ground. As we have seen, there *is* a market failure in this case, because the market undersupplies social egalitarian public goods. Principle (a) therefore does not imply that we should countenance the inequalities that would result from free contracting.[9] Moreover, (b) is questionable, because each citizen will deny that this opportunity set is the most valuable one they could face. Considering both their prudential and social values, they prefer not to face this choice at all (so long as this choice is removed from everyone). A responsibility-sensitive egalitarian should, I submit, object to inequalities that result from choices that no one wishes to face.

[9] Indeed, Dworkin (2000, pp. 155-8) endorses a "principle of correction" that requires that the state prevent such market failures. It follows that, if Dworkin had accepted my argument that social egalitarian goods produced by health insurance are public goods, then he would have had to withdraw his claim (quoted above) that a society of Avys who were all left free to choose Medium "could not be criticized on grounds of justice."

In sum, we have established that even equally-situated citizens who could enter a market without adverse selection problems may have social egalitarian reason to consent to be forced to buy a package of insurance. When all citizens do so consent, there is a decisive case for a mandating such a package. But we should also consider the more complex and more realistic scenario in which some citizens would consent to the mandate but others would not, because, for them, the gain in social equality is not worth the loss of liberty and the cost to their expected well-being. In these circumstances, we face a conflict of values between, on one side, the liberty and prudential interests of those who oppose a mandate and, on the other side, egalitarian public goods that cannot be generated through unconstrained individual choice. We also face a conflict of opinions between those who favor and those who oppose a mandate.

In deciding such conflicts, it is relevant whether the public goods whose provision is contested are necessary for social justice, or rather discretionary. It is more readily justifiable to limit the liberty and override the opinion of non-consenters when the good in question is necessary for justice than when it is discretionary (Klosko 1990). For example, forcing someone against their prudential interest to contribute a given sum in taxes to improve the judicial system is easier to justify than forcing someone, at the same prudential cost, to pay taxes towards public displays of art.

An important question is, then, whether solidarity and social equality should be seen as necessary or discretionary public goods. There is, I submit, a strong case that the goods of social equality are necessary. Just social co-operation is, naturally, both a matter of ensuring a fair distribution of relevant goods and opportunities and of maintaining the attitudes and relationships among citizens that prompt them to join in mutually beneficial projects and to

together deliberate about, and willingly adhere to, fair institutions and norms (Rawls 1999, pp. 125-6). These attitudes and relationships are valuable in themselves; they are also instrumental to securing fair distribution. Arguably, then, the goods of proper self-regard, civility and mutual respect that social egalitarians aim to promote are part of, and support, social justice (Rawls 1999, pp. 155-6 and 297-8). Moreover, the bads that they aim to prevent—domination, marginalization, and destabilizing attitudes—are obstacles to social justice.

In contrast, meeting the demands of a robust form of solidarity seems to be a discretionary public good. The ideal I have in mind requires strong fellow-feeling with the misfortune of co-citizens and condemns outcome inequalities even when these are consistent with pluralist egalitarian distributive principles and people's status as equal citizens. While some may reasonably want a robustly solidaristic society, such conformity is not required by justice. If some citizens wish to limit their own and non-consenting others' health insurance choices because the solidaristic public good they desire cannot be secured without such coercion, then their case is, like the case for imposing taxes to fund public art displays, comparatively weak.

Of course, the foregoing is merely one consideration. Deciding on the right degree of constraint in contested public goods cases demands careful balancing of the freedom and interests of some against the interests of others, and there is a good case for setting up fair procedures for resolving such substantive disagreement (Klosko 1990; Claassen 2013). Such balancing may also require the accommodation of non-consenters, especially when a mandate would not merely (as in our simple example) restrict the liberty to pursue one's prudential good, but also one's freedom to abide by central moral or religious convictions.

We may have reason to exempt conscientious objectors from the requirement to purchase coverage for particular procedures and even from the requirement to purchase coverage altogether.[10]

Let me conclude this section. I have argued that the operation of adverse selection in the insurance market is not essential to the justification of a mandate. For even when there is no adverse selection (because all individuals are known to be at equal risk), there is a different market failure that a mandate must solve, namely that an insurance package's contributions to establishing a society of equals constitute a public good. I have also argued that because social egalitarian relationships and attitudes contribute to social justice, we have strong reason to employ a mandate to secure this public good, even when its provision is contested.

What do social egalitarian considerations imply about the content of this mandated package? In our simple Identical Prospects Case, they are assumed to require a more comprehensive package than what prudential considerations alone would lead people to select. In more realistic cases, social egalitarian concerns will rather require the purchase of a minimum package that is in some respects more and in other respects less comprehensive than what people would purchase for themselves in a free market. Insofar as the cost of an increase in the mandatory package is disproportionately borne by those who end up better off, the

[10] For example, the Netherlands exempts those with demonstrably profound religious or moral objections from its otherwise rigorously enforced requirement to purchase private insurance. In 2013, an estimated 12,600 people, or 0,08% of the population, were granted this exemption (Maagdelijn and de Bekker 2014).

mandatory package will include more preventative and curative interventions aimed at those who end up less well off. It will also include more interventions that target threats to equal standing and social participation. But it may also exclude some interventions that people may wish to insure themselves for, because these interventions make no substantial contribution to social equality. Of course, the fact that coverage for these interventions is not mandated does not mean that individuals would not be permitted to purchase such coverage independently. Indeed, many societies that operate mandatory minimum insurance permit individuals to do so (the United States and the Netherlands are examples).

Conclusion

I have put forward a revised liberal egalitarian account of mandatory health insurance. On this view, a mandate can be justified because of its role in overcoming two problems that would occur in a free market without such a mandate. The first is adverse selection, which occurs in a particularly problematic form when we require that those with unfairly elevated health risks pay similar premiums to those at low risk. The second is a failure to provide the public good of social equality.

I have also argued that the content of the mandatory package should not be determined by asking what a representative prudent individual would purchase for themselves. Instead, it should be determined by a direct appeal to (at least) the following values: improving people's well-being, brute luck equality, and social equality, with a robust form of solidarity as a discretionary further value. Compared to a package that a representative prudent individual would want, these values will typically prompt us to include more coverage for

interventions that help the worst off, as well as more coverage for interventions that prevent the ills of domination, social exclusion, and loss of self-respect.

What, then, should we say to Mark and Lucinda, sensible people of average means and moderate current health risk who are compelled to purchase a more comprehensive and therefore more costly package than they desire?

First, that in order to offer fairly-priced insurance to everyone, including people who, through bad luck alone, face higher health risks than they do now, we have to require everyone to purchase a minimum amount of insurance. While this will raise their current premiums, it will also lower their premiums should they eventually face high health risks. By protecting others, they are therefore also protecting themselves.

Second, we should ask them to consider that, because of its universal adoption, the package will shape the society they live in. Additional coverage for conditions that leave people especially vulnerable and isolated will result in less corrosive inequality and better prospects for people to participate in public life as equal citizens. In short, we should say that a mandate is necessary because fair access to health insurance and a less divided society are things that we can only produce together.

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