

# Individual responsibility for what? – A conceptual framework for exploring the suitability of private financing in a publicly funded health-care system

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**Abstract:** Policymakers in publicly funded health-care systems are frequently required to make intricate decisions on which health-care services to include or exclude from the basic health-care package. Although it seems likely that the concept of individual responsibility is an essential feature of such decisions, it is rarely explicitly articulated or evaluated in health policy. This paper presents a tentative conceptual framework for exploring when health-care services contain characteristics that facilitate individual responsibility through private financing. Six attributes for exploring the suitability of private financing for specific health-care commodities are identified: (i) it should enable individuals to value the need and quality both before and after utilization; (ii) it should be targeted toward individuals with a reasonable level of individual autonomy; (iii) it should be associated with low levels of positive externalities; (iv) it should be associated with a demand sufficient to generate a private market; (v) it should be associated with payments affordable for most individuals; and finally, (vi) it should be associated with ‘lifestyle enhancements’ rather than ‘medical necessities’. The tentative framework enables exploration of individual responsibility connected to health care as a heterogeneous group of commodities, and allows policymakers to make decisions on rationing by design rather than default.

## Introduction

A fundamental objective of tax-funded health-care systems is to grant universal access to public health-care services and make it affordable at the point of use.

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This implies not only a public obligation to improve health, but also to protect people from the financial costs associated with treating poor health. However, the scarcity of public funds inevitably makes it impossible to fund all services that are medically feasible. Consequently, policymakers within a system of essentially publicly funded health care are frequently faced with intricate decisions about which health-care services to exclude and thus require individuals to finance privately. Such health-care rationing can be done in two ways: either by excluding services that were previously reimbursed or by denying reimbursement for new medical services. Moreover, public spending in areas where individuals are capable of taking financial responsibility inescapably diverts resources from those areas where individuals are unable to take such responsibility. Thus, an important aspect to consider when trying to achieve a fair health-care distribution is which characteristics of services might actually facilitate individual financial responsibility for their own health care. Given the increasing public demand for transparency in health-care rationing, welfare societies face the challenge of explicitly articulating what role individual responsibility should play in a public health-care system – the key issue explored in this paper.

Within economics, the standard approach for determining what health care to include or exclude from public funding has been cost-effectiveness analysis (CEA), in which health-care services are ranked by the ratio of their costs to their health effects. Those services with a ratio below the threshold of what society is willing to pay for a unit of health gain, are recommended for exclusion from the publicly funded health-care package. However, even though CEA is a powerful tool for input of information into the priority-setting process, the approach is nevertheless subject to several limitations that constrain its practical use as a guiding principle for rationing. First, cost-effectiveness studies are seldom homogeneous in terms of methodology, which sometimes makes comparisons between different settings potentially misleading (Drummond *et al.*, 1993). Second, there is no uniformly accepted standard practice for incorporating future unrelated costs or benefits that may accrue in other parts of society (Garber and Phelps, 1997, 2008; Meltzer, 1997). Third, the cost-effectiveness ratio gives no information regarding the magnitude of the total budget effect an inclusion or exclusion will have. Even if the methodological shortcomings of CEA are disregarded, it still fails to take into account a wide range of factors and constraints that may be of importance in the priority-setting process. Most importantly, it does not explicitly consider distributional effects and fails to take into account the fact that some services may or may not be available for purchase out-of-pocket if not covered publicly, with obvious consequences for individuals' possibility of taking responsibility for their own health care (Hoel, 2007). Consequently, the standard economic approach towards health-care rationing fails to take contextual factors into account, important for the feasibility of individual responsibility. This makes CEA insufficient as an exclusive tool for rationing decisions.

The potential role of individual responsibility in health care policies is not a new topic. However, most of the earlier work on individual responsibility in health care has centered on the moral relevance of responsibility with regard to risk factors for poor health (Minkler, 1999; Wikler, 2002; Olsen *et al.*, 2003; Cappelen and Norheim, 2006; Buyx, 2008), and thus mainly discusses individual responsibility for own health-related behavior. This discussion includes the debate about whether those who take bigger risk with their health should pay higher taxes. However, an issue of equal importance is whether the characteristics of a specific health-care service and the applicability or shortcomings of market forces surrounding the specific service are such that the individual reasonably could – or could not – be given responsibility for financing the service in question. The health care required by certain health states may sometimes be fully manageable by the individual. In this paper, we will disregard responsibility in terms of underlying factors for health-care need (i.e. health risks). Instead, we will explore responsibility in terms of the health-care services that individuals are capable of financing and managing without public involvement or subsidies – a conception of individual responsibility more relevant in the policymaking context (Le Grand, 2003).<sup>1</sup>

Although the concept of individual responsibility is a necessary consequence of any substantial amount of freedom and therefore present in practically all areas of society, it is rarely articulated or used as a rationing principle in the health-care context. Many have resisted the idea of assigning individual responsibility an explicit role in health-care rationing, because of the risk of intentional use to legitimate inequalities in health. At the macro policy-level, the Netherlands is the only country we are aware of that has explicitly stated individual responsibility as a possible principle for health-care rationing (Government Committee on Choices in Health Care, 1992). Its proposed system for priority-setting is constructed as a funnel with four criteria aimed to distinguish services that should receive funding, from those that should not. The four criteria are: Is the treatment necessary? Is it effective? Is it cost effective? And – as a final gate-keeping criterion – whether or not the service can be made the responsibility of the individual. Based on this system, services such as *in vitro* fertilization, homeopathic medicines and dental care for adults were excluded from publicly funded health care. Even though the system initially received a lot of attention in public debate on health-care rationing and individual responsibility, its actual effect on rationing in the long run has remained limited. Two plausible explanations for this limited influence are: poor operationalization of the criteria and the fact that all criteria are intended to lead to a yes or no answer to funding, while a decision maker weighs the criteria against each other (Stolk *et al.*, 2002).

In Sweden, explicit priority-setting principles based on ethical core values have also been defined at the macro policy-level. These principles are supposed

1 See, for example, Barry (2005).

to guide local and regional authorities when constructing rationing policies. The principles are: First, the principle of human dignity, meaning that all individuals have equal rights regardless of personal characteristics and position in society; Second, the principle of need and solidarity, meaning that resources should be used in domains (or patients) where needs are considered to be largest; Third, the principle of cost-effectiveness, meaning that resources should be used in the most effective way without neglecting fundamental duties concerning the improvement of health and quality of life. Individual responsibility was explicitly dismissed as a legitimate principle for priority-setting at the macro level.<sup>2</sup> Nevertheless, there are still a wide range of health-care services in Sweden that are subjected to rationing which cannot fully be explained by any of the existing guiding principles. For example, dental care for adults, eye-glasses, some vaccinations, over-the-counter drugs and a fair share of assistive devices are all subject to extensive individual responsibility, in the sense that they are available if you want them and have the ability to pay for them. This seems to indicate that, although formally dismissed, the individual capacity of responsibility constitutes an important aspect, in addition to established principles, in decisions on rationing in the Swedish health-care setting. It also illustrates that it is seen as acceptable to allocate health care through market mechanisms under certain circumstances.<sup>3</sup> But because the rationing of health-care services most often has taken the form of incremental initiatives rather than direct cutbacks, these circumstances have remained unclear.

At the meso policy-level, there have been no attempts, which we know of, to explicitly take individual responsibility into account. There has, however, been some attempt to explicitly make 'rationing-lists' that are less generic compared to the macro-level policies described above. The most prominent example was undertaken by the state of Oregon; in the early 1990s, Oregon used an explicit process for rationing based on the ranking condition–treatment pairs according to their cost-effectiveness ratio. The initial rankings resulting from this process seemed counterintuitive in some cases and invoked strong negative public reactions. Public consultations were used to adjust the initial ranking. For example, some cancer treatments and appendectomy were initially ranked lower than capping teeth (Hadorn, 1991). In Sweden, explicit rationing at the meso level was undertaken by the County Council of Östergötland, in 2003, which

<sup>2</sup> The commission assigned to prepare the law briefly motivated their dismissal by stating that the relationship between behavior and disease is not generally understood, as genetic factors have importance for the onset of certain diseases and harmful behavior to health is usually acquired early in life (Swedish Parliamentary Priorities Commission, 1995). Thus this objection is not relevant to the issue concerning financial responsibility for health care which this paper aims to explore.

<sup>3</sup> In addition, the attention of health-care policies is increasingly directed towards the interplay between private and public responsibility. See, for example, the controversy surrounding cost-sharing by patients in the UK National Health Service (National Health Service, 2009) or in Germany, where recently, policies have been implemented within the national insurance system not to fund health care related to certain 'lifestyle choices' (Schmidt, 2007).

developed a set of explicitly defined limitations on health-care provision. Examples of services that got excluded from public funding were: treatments for simple childhood conditions (e.g. head lice, obesity) would no longer be treated in pediatric clinics, and patients had to pay for a second hearing aid privately.

The aim of this paper is to present a tentative conceptual framework, to be used within a system of principally publicly funded health care, for exploring when health-care services exhibit characteristics that facilitate individual responsibility for private financing. Our emphasis here is not to dismantle public funding for health care but rather to move society in a welfare-promoting direction by exploring combinations of public and private financing that may improve overall welfare. The article is divided into five sections: The first defines the concept of individual responsibility that we will focus on. The second section outlines the rationale for exploring health care as an economic commodity, which in some cases may be suitable for private financing. The third section reviews the characteristics that distinguish health care in general from other economic commodities, which potentially could make allocation through market mechanisms less suitable. In the fourth section, we present a tentative conceptual framework, based on the preceding arguments, exploring when the characteristics of health-care services might facilitate individual responsibility for private financing. The last section discusses the potential use and limitation of the conceptual framework.

### **Defining individual responsibility in health vs health care**

Although individual responsibility in general is a prominent topic in the public debate, a common understanding of how this concept may be applied to health and health care is lacking. This is understandable because individual responsibility is a complex concept that may be interpreted in various ways, depending on context.<sup>4</sup>

But in order to have a meaningful discussion concerning individual responsibility as a rationing criterion, we need to clearly distinguish the different conceptions of responsibility and isolate those that are relevant from a health-care policy perspective. To do so, we first need to address the question: responsibility in what domain? Fleurbaey (1995) proposes that individual responsibility in terms of health-care funding can be assigned to two separate domains – factors or outcomes. We will refer to these domains as responsibility for health (factors) and responsibility for health care (outcomes).

The first domain, ‘responsibility for health’, is assigned when individuals are held responsible for the evolution of factors that eventually may affect health outcomes. If applied as a rationing principle, individual responsibility for health would imply that society compensate health disadvantages beyond individual control while implicitly penalizing behavior that is deliberately unhealthy. In

4 See, for example, Hart (1968) for illustrative examples.

most general theories of justice, this control-based notion of responsibility is given a central position. Rawls (1971), for example, points out that any autonomous moral agent should take responsibility for their personal conception of a good life, implying that how people use their equally distributed rights and resources should be a matter of individuals' responsibility. The luck egalitarian approach towards fairness and responsibility centers around the idea that individuals should be held accountable only for the consequences of their own deliberate choices, while the public should compensate individuals suffering as a consequence of brute luck,<sup>5</sup> that is, factors outside one's own control (Arneson, 1989; Cohen, 1989). This control-based notion of responsibility, represented by luck egalitarianism, has however been criticized as morally impermissible as it could lead to what Anderson (1999: 296) calls, "the abandonment of negligent victims". Furthermore, luck egalitarianism can also be criticized for being too broad, such that it could expand the scope of health policy beyond plausibility if put into practice. For example, an individual who is dissatisfied with the looks of his nose and wishes to have plastic surgery cannot be said to have caused his unattractive nose through deliberate choice. Additionally, many of the choices influencing health might have been influenced by social factors or inadequate information. In a policymaking context, the notion of responsibility for health is therefore arguably of little relevance as it is difficult to settle which health-related choices fall within individual control.

The second domain, 'responsibility for health care', disregards underlying factors and focuses solely on the health outcomes individuals are capable of managing without direct public involvement or subsidies. Within welfare economics, individual responsibility is generally seen as a necessary element for limiting the scope of collective responsibility. The distribution of commodities through the market is the most prominent example of which individuals are assigned responsibility for any combination of goods they end up with. This shows that "responsibility is a necessary consequence of any substantial amount of freedom and is therefore part and parcel of any free society" (Fleurbaey, 2008: 1).

When focusing on responsibility for health care, the delicate but central feature of moral blame that is present when assigning responsibility for health is removed. This is why policies regarding individual responsibility most often are restricted to the health care domain, because this is also politically less sensitive (Le Grand, 1987). Consequently, the most policy-relevant concept of responsibility concerns health care, instead of health, and focuses on whether a person has the capability to take on responsibility for certain health care.

Given these issues, we will not, in this paper, explore the notion of responsibility for health as a potential rationing principle. Instead, we focus on the

<sup>5</sup> Dworkin (1981) initially made the now famous distinction between brute luck and option luck, and argued that individuals should be responsible for the latter but not the former. Option luck is defined as those cases where individuals voluntarily and deliberately have submitted to a particular risk.

possibility and suitability of assigning individual responsibility for the financing of health care, that is, to leave it to the individual to privately finance certain kinds of health care. The practical application of individual responsibility for health-care commodities, which we explore in this paper, depends on whether or not individuals have the cognitive and physical capability of exercising their responsibility and whether or not the surrounding settings facilitate the taking of responsibility by the individual. Therefore, the characteristics of specific health-care services and the applicability or shortcomings of market forces in health care are two critical issues to be analyzed when assessing the capability of individuals to take responsibility for the financing for specific health-care services.

### **Health care as an economic commodity**

Before exploring the distinguishing characteristics of health care as an economic commodity that might influence the capability of individuals to take responsibility, we first need to answer the question of whether or not health care really is a commodity. And moreover, what are the advantages of analyzing it as such?

The common definition of an economic commodity is that it is something that is produced and may be sold, exchanged or provided free. The commodity 'health care' can consequently be defined generically as all kinds of services and goods whose primary purpose is to improve or prevent deterioration of health and that may be sold, exchanged or provided free. The commodification of health care is sometimes criticized by individuals who argue that health is a basic right that a society has an obligation to protect from commercialism and immoral market forces, as 'health has no price'. The argument that health care constitutes a basic right and therefore should be distributed in accordance with need, and not in accordance with the ability to pay, is the most common objection to treating and analyzing health care as a commodity. It is easy to agree that need should be of great importance when distributing health care. However, this does not mean that health care is unsuitable for purchase and sale and cannot be analyzed as a commodity. The mere fact that something is considered to be a basic right does not imply that it cannot also be a commodity. For example, while food and shelter are often considered to be basic rights, they are also commonly treated as transferable commodities. More fundamentally, the commodification of health care does not preclude moral considerations. Rather, it highlights the effects of potential transactions so that policymakers can make informed decisions about the allocation of scarce resources.

The second most commonly proposed objection to treating and analyzing health care as an economic commodity is:

The central feature of health care is the personal relationship between a health professional and a person seeking help ... commodities may be used in the process of providing care, but the totality of health care itself is not a commodity.

(Pellegrino, 1999: 247)

Our interpretation of this objection is that it relates to the notion that ‘health’ should not be seen as a commodity to be bought and sold on a market. However, health is not equivalent to health care, which is simply an input to the production of health (Grossman, 1972, 2000). This is an important distinction as there are many factors that influence health, and health care is just one of these. But health care is an input factor that unlike many other factors, such as genetics, may be, and often is, distributed on a free market (which does not necessarily mean that it always should be). Consequently, despite the criticism, there can be no doubt that ‘health care’ is produced, distributed and its demand is influenced by its price, so evidently it can be considered as a commodity.

However, treating or analyzing health care as a commodity does not imply that it constitutes a homogeneous group of goods and services. On the contrary, there is a great deal of heterogeneity among health-care services. This heterogeneity constitutes a major reason why a more structured framework for exploring which services to include in or exclude from the basic health-care package is needed, instead of applying an arbitrary general attitude towards public or private funding. Moreover, treating health care as a commodity does not necessarily imply that private financing is required.

The main advantage of approaching health care as a commodity is that this allows us to consider the substitutability and heterogeneity of health care in a more structural and transparent way. Further, it allows us to study decisions and their underlying incentives as they relate to the production, distribution and consumption of health care when resources are scarce and can be put to alternative uses. Thus, to disregard the applicability and shortcomings of market forces when deciding how to finance and allocate scarce health-care resources would be both unhelpful and morally irresponsible.

### **Health care as an economic commodity – in what ways is it different?**

Despite the fact that health care may be considered a commodity, it differs in important ways from other commodities, which makes it unsuited for distribution through the workings of price mechanisms on a free market. This idea of market failure in the market for health care has been a repeated topic since economists first started to focus on the health-care sector during the 1950s (Mushkin, 1958; Arrow, 1963; Culyer, 1971; McGuire *et al.*, 1988; Pauly, 1988a, 1988b; Hurley, 2000; Folland *et al.*, 2001; Donaldson and Gerard, 2005). In the following section, we will briefly refer to some of the familiar arguments on what distinguishes health care from other commodities, for the purpose of examining how such differences might influence the possibility of individual responsibility for health care.

The distinctiveness of health care compared to other standard commodities may be derived from four characteristics of health care. First, the demand for health care is a derived demand for health. Health care is simply an input to the

production of the desired good, which is health (Grossman, 1972, 2000). Most of the other commodities are usually consumed because they generate instant utility, whereas health care most often generates disutility before better health is produced.

Second, health care involves a great deal of informational asymmetry between patients and doctors. The behavior that a patient expects from doctors clearly differs from what a consumer expects from most other sellers/producers. This is because the health-care commodity does not exist independently of its production, which hinders the potential consumer from testing health care before consuming it. There is an obvious element of trust in the relationship, which implies that the doctor needs to be concerned about the well-being of the patient (or at least appear to be). Such a trust bond between provider and purchaser cannot be expected in other economic areas, at least not to the same extent. Further, as medical knowledge is often very complicated, it creates an asymmetric relationship between the consumer and the provider regarding the need for, and possible consequences of, receiving health care. The patient often does not have (or at least he often believes he does not have) as much knowledge as the doctor and can not thoroughly examine or question the health care prescribed. There is less possibility of accurately judging the need and quality of health care from past experiences because the occurrence of a disease is often as unpredictable as the recovery from it (Arrow, 1963; Weisbrod, 1978; McGuire *et al.*, 1988). To be well-informed, health-care consumers should be able to distinguish differences in health state with and without consumption of the commodity<sup>6</sup> (Weisbrod, 1978).

The third way health care differs from other commodities is that both the possible future need for and outcome of treatments are often objects of great uncertainty. Widespread uncertainty and the risk of catastrophic expenditures are generally dealt with by insurances in most markets. However, in terms of the health-care market, there are many groups of people with considerable certainty about their future demand for health care, for example, people suffering from chronic diseases or permanent disablement. These groups are uninsurable in a private insurance market with actuarially fair premiums. Public intervention is required in order to secure financing. On the other hand, compulsory insurance against some medical expenditure may also be non-optimal due to the existence of moral hazard, for example, compulsory insurance might create excessive disincentives for individuals to take preventive measures for their health (Pauly, 1968).

Fourth, health care is frequently associated with the existence of positive externalities. Individuals, although behaving perfectly rationally, may not consume

<sup>6</sup> In order to limit the extent to which health-care providers deviate from their agency responsibilities, society often uses constraints such as non-profit organizational form, licensure and accreditation, or imposes codes of ethics to discourage exploitation of ill-informed patients.

sufficient health care in the opinion of other individuals in society, as most of the positive effects fall on others. The origin and magnitude of these externalities may however differ depending on circumstances: (i) People may obtain satisfaction from knowing that sick and poor people consume health care (caring externalities). (ii) People may not understand their own good or lack the foresight to purchase health care if it is not publicly provided<sup>7</sup> (paternalistic externalities). This type of commodities which society desires to provide in quantities greater than what consumers wish to purchase at market price are commonly referred to as merit goods (Musgrave, 1959). (iii) People may obtain increased welfare as a ‘technical’ positive effect from other people’s consumption of health care (selfish externalities). For example, it may be assumed that healthy individuals contribute more to society in terms of production and economic growth than sick people. (iv) Finally, people may place a value on having health care available for potential use, which they may require at some future time (option-value externalities). The irregularity and unpredictability in demand for certain health-care services is a potential problem in ensuring sufficient capacity for those who do not currently require health care, but might require it at some later date.

It is important to note that none of the four characteristics outlined above are entirely unique to health care. Quite the opposite, it is rather easy to recognize other types of commodities that are similar in terms of the asymmetrical distribution of information, uncertainties regarding stochastic events and externalities. Still, the presence of all four of these characteristics at the same time is relatively unique for health care.

In addition to concerns about potential market failures associated with the commodity of health care, the financing of health care also raises serious distributive and social issues. Within welfare economics, concerns about efficiency are traditionally separated from concerns about distribution of wealth and health by maintaining that allocations generated through functioning markets are Pareto optimal, meaning technically and allocatively efficient (Reinhardt, 1998). Hence, economic evaluations most often focus merely on efficiency, leaving distributional concerns to the political process.

Among theories of distributive justice, two common ideas are that: resources should be distributed equally and that the distribution should depend on choices for which individuals can be held responsible. However, these two core ideas – equality in resources and responsibility for one’s consumption choices – can conflict somewhat. To a certain extent, full equality<sup>8</sup> denies individuals the possibility of acting with full agency. This can be viewed as incompatible with

<sup>7</sup> By ‘publicly provided’ we mean health-care that is financed publicly, NOT that it is publicly produced.

<sup>8</sup> Full equality is here defined according to resource egalitarianism, in which everyone gets the same share of the goods to be distributed, regardless of an individual’s capacity to benefit. See, for example, Arnesson (1989) and Cohen (1989).

the concept of responsibility (Lake, 2001). An extensive amount of literature has covered different aspects of allocation concerning health and health care (Whitehead, 1992; Culyer and Wagstaff, 1993; Barer *et al.*, 1998; Sen, 2002). We will therefore not go into a lengthy discussion regarding equity in health, but be content with pointing out that as long as resources are scarce, health-care inequalities will always exist. It will however be taken for granted that equality of excess is an important policy goal.

Health care is a commodity which in many cases is of special moral importance because it protects the range of capabilities or opportunities open to people and enables them to live up to their own conception of a good life (Sen, 1992; Daniels, 2008). Hence, society has an obligation connected to its distribution that does not apply to most other commodities. This special moral importance does not, however, help us to decide which inequalities in health care are unfair. Consequently, the appropriate question to pose when rationing health care and assigning individual responsibility through private financing should be: which inequalities in health care are acceptable or justifiable from a societal point of view? This question will be explored further in the next section of the paper.

### **Attributes for individual responsibility – a conceptual framework for exploring the suitability of private financing in a publicly funded health-care system**

When is it possible from a market perspective, and reasonable from an equity perspective, to introduce individual responsibility for health care? In the following section, we combine our defined notion of individual responsibility for health care with the distinctive features of health-care commodities in order to present a tentative conceptual framework for determining when health-care services possess such characteristics that they warrant individual responsibility through private financing.<sup>9</sup> This framework consists of six attributes that should be present in order to make private financing morally justifiable.<sup>10</sup>

#### *The concept of sufficient knowledge*

The first attribute in the framework centers around the limitations that the existence of informational asymmetry between patients and doctors puts on the feasibility for individual responsibility. To allow private financing for a

<sup>9</sup> The suitability of specific private financing mechanisms such as co-payments or co-insurances is, however, beyond the scope of this paper.

<sup>10</sup> Norman Daniels and James Sabins' (2008) set of procedural principles for a making health care priority-setting decisions fairly, entitled 'Accountability for Reasonableness', has become the dominant paradigm for resolving disputes about conflicting attributes or values in health policy. The framework presented in this paper should be seen as a set of substantive principles which are needed to complement such procedures. We would like to emphasize the complementarities between procedural and substantive principles, although in this framework, we focus only on the latter.

health-care service, consumers' ability to value benefits both before and after consumption is essential. When individuals consume most other commodities, they are able to test the product and return it if it does not fulfill its purpose or patronize a different producer for future usage, for example, switch to a different restaurant or a plumber. In contrast, for many health-care services, patients are not able to test and obtain this sort of information about quality and possible utility of a certain treatment. For example, given her lack of medical expertise, a patient undergoing cytostatic treatment for cancer or in need of acute lifesaving treatment has little ability to test and obtain information about the treatment's quality and effects. Consequently, if a doctor tells a patient that an expensive treatment is necessary, most people would not be in a position to question this. In addition, the need for many medical services does not recur (at least not frequently), which prevents consumers from building knowledge from past experiences.

At the same time, there are also several health-care services where patients can be considered fairly well informed about quality and possible benefits. Pauly (1978) discusses how widespread information asymmetries in the health sector are, and suggests that at least one-fourth of total private health-care expenditures is associated with situations where patients can be regarded as 'reasonably informed'. If we include expenditures for nursing home services and chronic conditions, this share increases to approximately one-third (Pauly, 1988a, 1988b). Glasses, over-the-counter drugs and most assistive devices are other examples of services for which consumers and providers have the same informational basis as they do for many non-health-care commodities. Given such examples of reasonably informed consumers, it is clear that there exist plenty of health-care services where individuals have sufficient knowledge to facilitate taking responsibility for making informed decisions about what services to consume.

Attribute 1. The considered health-care service should enable individuals to value the need and quality both before and after utilization (consumption).

### *The concept of individual autonomy*

A crucial assumption in welfare economics is that in order for markets to function efficiently, individuals must be capable of knowing and expressing what is best for themselves and make rational choices which maximize their personal well-being. When this assumption is violated, there will typically be inefficient markets. Within behavioral economics, the concept of bounded rationality revises this assumption to account for the fact that perfectly rational decisions are often not feasible in practice, due to the finite computational resources available for making decisions. Although individuals may have sufficient knowledge to assess need and quality, they still may lack insight about how their preferences correlate with their more fundamental needs.

Such bounded rationality extends to health care. When consuming health care, individuals are frequently unable to make rational choices whether to

consume a suggested treatment. Moreover, certain patient groups persistently make inferior decisions in terms of their own welfare – decisions that they would revise if they were equipped with full cognitive ability or full self-control. Consequently, determining the level of individual autonomy of the targeted group is essential when deciding whether it is appropriate to require private financing. Levinsson (2006) sets up four possible conditions that can be used to determine the level of autonomy of health-care consumers: the ability to be self-reflective and well reasoned; the ability to act in coherence with their intentions; the ability to understand relevant information; and the ability to foresee the consequences of their behavior.

Individuals that lack these cognitive capabilities are vulnerable to exploitation, to suffering harms and inability to give adequate consent. We can identify at least four patient groups that illustrate the concept of limited autonomy in connection to health care. The first group consists of individuals with limited cognitive abilities that make it difficult for them to foresee the consequences of their actions. These individuals may, therefore, fail to demand treatment when it is supplied on a free market. The second group consists of patients requiring emergency treatment. These individuals are frequently not in a position to express well-reasoned preferences or self-reflective enough to assess relevant information. The third group comprises individuals with addictive behavior. These individuals often have trouble acting in coherence with their intentions because of their addiction, which arguably might disqualify them as rational consumers.<sup>11</sup> The final group consists of children; however, in most cases they have guardians who are able to make rational choices for them (Culyer, 1971).

It is important to note that even if individuals have a high level of autonomy, this does not necessarily imply that they are not influenced by their surroundings but rather that they have the capability to make decisions that can be considered well-reasoned (they might still not always appear well-reasoned in the opinion of others). In addition, it is also important to note that health-care services aimed at a group with low levels of individual autonomy should not automatically be offered free of charge. However, the provision of these health-care services need to be publicly regulated to avoid exploitation of groups that are not capable of acting as rational consumers.

Attribute 2. The considered health-care service should be directed towards individuals with a reasonable level of individual autonomy.

### *The concept of positive externalities*

The third attribute of the framework focuses on the existence of external benefits associated with the consumption of health-care services, that is, benefits

<sup>11</sup> Thus, we believe that the concept of rational addiction is problematic when it comes to actual decisions on health-care consumption (Becker and Murphy, 1988).

accruing to persons other than the patient in focus of an intervention or to the public at large. Due to public interest, society may wish to subsidize services with so-called positive externalities, such as vaccinations against epidemic diseases. There are at least three separate types of externalities that need to be considered.

The first type of externalities are what Culyer calls “caring externalities”, which arise because “individuals are affected by others’ health status for the simple reason that most of them care” (Culyer, 1976: 89). In other words, the sick person’s pain and lack of treatment cause disutility for other people in society. It has been argued that the existence of caring externalities is the main reason for the existence of the publicly funded welfare state (Culyer, 1980; Evans, 1984).

The second type of externalities are paternalistic externalities related to the existence of merit goods. These arise when society in general feels that individuals in particular circumstances ought to consume health-care commodities based on norms rather than leaving consumption to consumer rationality. For example, merit goods such as many keep-fit activities are subsidized, while goods viewed as demerit goods, such as tobacco and alcohol are taxed in order to reduce demand (Evans, 1984). These paternalistic attitudes arise because caring for the sick is often seen as a virtue in communities. The individual does not necessarily care about the improved health or utility of others, instead, the positive effect is limited to the instrumental act of affecting the consumption patterns in various ways. This distinguishes paternalistic externalities from caring externalities in view of the fact that the latter are concerned with the actual health status of the persons concerned (also called specific altruism) (Jacobsson, 2005).

The third type of externalities are what we here refer to as ‘selfish externalities’. Some health-care services might, for example, determine whether or not a person is able to proceed with a certain job and thus generate positive externalities to society as a whole. Many assistive devices may increase the potential for individuals to manage without personal assistance from relatives or others, and this benefit could be considered as a selfish externality.

Attribute 3. The considered health-care service should be associated with low levels of positive externalities.

### *The concept of sufficient demand*

The fourth attribute that needs to be taken into consideration when exploring the feasibility of individual responsibility through out-of-pocket payments is whether demand is regular and of a reasonable magnitude. Relying on private financing to support certain health-care services for which demand may be irregular and unpredictable, would lead to insufficient capacity to provide those services in the future (option-value externality). For example, in some sparsely populated areas, the demand for health-care treatment is insufficient to support

a system based exclusively on private financing. Consequently, health care may need to be financed collectively if society wants to ensure health-care capacity outside heavily populated areas, or if it wishes to ensure capacity to treat extremely rare and complicated illnesses.<sup>12</sup>

Attribute 4. The considered health-care service should be associated with a demand of sufficient magnitude to generate a private market.

### *The concept of affordability*

The fifth attribute is the affordability of specific services, that is, payments of a reasonable magnitude for most individuals. Because wealth and income are distributed unequally between individuals it is hard to set a definite boundary for what constitutes an affordable price. However, if society wishes to limit the influence of economic inequality on the consumption of health care, then affordability needs to be taken into consideration. Therefore, a financing system needs to include arrangements for exemptions and/or high-cost protection in order to protect individuals from unaffordable and catastrophic health-care payments. The absence of such arrangements would result in scenarios likely to violate the general public's notions of 'equity' and 'fairness' (Hauck *et al.*, 2004). Consequently, there is a need to make exemptions or price reductions in any generalized system for the use of private financing, in order to gain public acceptability.

The concept of affordability is most commonly used in policy discussions in the context of out-of-pocket payments, but unfortunately the meaning of affordability most often remains obscure, both in general discussions and in more rigorous economic analyses. Bundorf and Pauly (2006) give a normative definition of affordability that can serve as a frame for further specification: "The special good is affordable to an individual if her income after the purchase of the socially acceptable minimum quantity of the good is greater than or equal to the socially defined minimum spending on other goods" (2006: 653). Hence, an affordability threshold needs to be defined in order to further make the concept of affordability operational and this can be done in various ways. Ultimately, defining affordability is as much a political and normative task as it is an economic one.<sup>13</sup>

The stochastic nature of medical expenditures makes it very difficult for individuals to incorporate these expenditures when planning household budget. Consequently, the concept of affordability implies that the services which are appropriate for private financing, are generally those that will not inflict

12 Of course, some health-care products can be kept in storage and therefore do not require high demand. License requirements for treatment and prescriptions may limit the incentive for a local profit-maximizing entrepreneur to enter a low demand market without public funding (Donaldson and Gerard, 2005).

13 In this way, affordability is not very different from applying a societal willingness to pay for a particular service or a quality-adjusted life year (QALY).

widespread catastrophic payments out-of-pocket. Moreover, because private insurance will not be available for everyone in an insurance market with actuarially fair premiums, low-cost services are generally more suitable for private financing.

Attribute 5. The considered health-care service should be associated with payments affordable for most individuals.

### *The concept of lifestyle enhancement*

The final concept, lifestyle enhancement, is to some degree separate from the preceding concepts in the sense that it deals with how to define the core purpose of a health-care system. Rather than eliciting the feasibility of individual responsibility, the concept of lifestyle enhancement aims to avoid over-consumption or moral hazard that could threaten the financial sustainability of any public health-care system.

In order to achieve financial balance, a publicly funded system needs to match revenues against costs for actuarially predictable events. However, moral hazard – defined as over-consumption caused by facing less than full cost of service – threatens to undermine the balancing of revenues and costs. Moral hazard connected to health care is, however, a special case of moral hazard since health care simply is an input to the production of the desired good – health. Compared to other commodities, health care in itself is undesirable as it often generates disutility before better health is produced. Consequently, because moral hazard for medical treatments that deals with pain or symptom avoidance is limited, there is some degree of self-regulation in the health-care market.

There also exist a wide range of health-care services that do not involve any concept of illness or disease. These so-called ‘lifestyle enhancements’ are health-care services that aim to fulfill wishes outside the medical sphere. The risk for moral hazard in lifestyle enhancements is much greater than in other health-care areas, as the lack of disutility associated with such health condition or generated by the health-care service do restrain demand. Therefore, to maintain financial sustainability in public health-care systems, services associated with lifestyle enhancements need to be funded privately to some extent.<sup>14</sup>

In many countries, despite having been shown as highly cost-effective, health care for reasons other than disease or injury has been excluded from public funding. The most prominent rationing debate has concerned so-called ‘lifestyle drugs’. The exclusion of such health-care services from public funding has most often been justified by rationales implying that such health-care services are lifestyle enhancements or luxuries rather than necessities. Despite how commonly such terms are used, it is difficult to define what is meant by lifestyle enhancements or

<sup>14</sup> See Pauly (1968) and Zweifel and Manning (2000) for empirical examples on moral hazard related to health-care consumption.

luxury health-care, as these concepts are influenced by social and cultural norms (Reissman, 1999). The theory developed by the economist Tibor Scitovsky (1977) could be helpful in refining these concepts further. He distinguishes two sorts of utility gain, utility arising from ‘pleasure seeking’ (lifestyle enhancement) and utility arising from ‘pain avoiding’ (necessity consumption). ‘Pleasure seeking’ connected to health can be considered as those services that people desire in order to exceed a societal reference point for health (Stolk *et al.*, 2002). Such services could, for instance, be cosmetic treatments, doping or medication for erectile dysfunction.<sup>15</sup> Similarly, pain avoidance connected to health care can be considered as those services desired because patients are currently below a societal reference point for health, for example, cancer treatments. The reference point for health might, however, differ between societies and patient groups. For example, older people probably have a lower reference point than younger people, concerning many health states (Williams, 1997). A decline in mobility that is considered unacceptable for a 20-year-old is in many cases acceptable for an 80-year-old. Obviously, grey areas will arise in which it is unclear whether a service constitutes a lifestyle enhancement or a medical necessity. For example, it can be debated whether treatments that increase height, muscle capacity or intelligence, constitute enhancements rather than treatments for medical necessities. Distinguishing between what should be considered reconstructive surgery, and what cosmetic, is similarly difficult. However, certain ‘non-medical’ cases that seem to come close to treating an illness, for example, in cases when the desire to look differently causes significant psychological distress that it leads to seeking surgery. How then, should the line between treating an illness and treating a non-medical wish to be drawn? How do we determine which unwanted conditions are worthy of treatment? This, of course, is a very delicate issue, but it is the type of normative judgement that any public health-care system has to confront. As Sandel (2004) argues:

In order to grapple with the ethics of enhancement, we need to confront questions largely lost from view – questions about the moral status of nature, and about the proper stance of human beings toward the given world.

(Sandel, 2004: 51)

When these kinds of normative judgments have been made for a specific health-care service, it is important that the rationale for this decision is clearly stated and defended publicly so that this can serve as a ‘case law’ for similar policy decisions in the future. This will demonstrate coherence and consistency, which will strengthen the legitimacy of public decision makers in the long run.<sup>16</sup>

<sup>15</sup> How to distinguish medical usage of medication for erectile dysfunction, from lifestyle purposes is however debated vigorously; see for example, Gilbert *et al.* (2000).

<sup>16</sup> One approach for making such rationales transparent is offered by Norman Daniels and Jim Sabin in their framework Accountability for Reasonableness (A4R). For a more detailed discussion concerning A4R, see chapter four in Daniels (2008).

Attribute 6. Health-care services associated with lifestyle enhancements rather than medical necessities are eligible for private financing.

## Discussion

Decisions concerning the rationing of health-care services are made in all publicly funded health-care systems, and may significantly affect both individuals' health and broader economic situation. Therefore, it is of great importance to explicitly discuss the underlying logic for such decisions to avoid arbitrary and unfair allocation of health-care resources. Although individual responsibility connected to health care evidently is an influential factor for decisions on rationing, individual responsibility is seldom explicitly tackled in the literature concerning economics and public policy. This article is an attempt to bring some attention to the role of individual responsibility in health-care rationing – a matter we firmly believe benefits from multidisciplinary approaches to fill the gap between existing guiding ethical principles and economic approaches. The main objective of this article is to explore how the characteristics of health care, as an economic commodity, can be combined with distributive considerations into a conceptual framework for determining which types of health-care service can be left to individual responsibility through private financing.

As emphasized in this paper, health care does not consist of a homogeneous group of commodities, and consequently, decisions on rationing cannot be computed through a simple formula. The framework developed in the paper should be used to explore health care as a heterogeneous group of commodities, rather than applying an all-or-nothing approach to inclusion or exclusion in the publicly funded health-care package. We argue that adopting this approach to health-care rationing has many advantages, especially in that it forces decision makers to explicitly define the objectives of the rationing or priority-setting process, even if these objectives cannot always be easily observed or measured. By supporting decision makers with substantive concepts and attributes focusing on health care as a commodity, we hope that our tentative framework will constitute a good point of departure for exploring the feasibility of individual responsibility when it comes to funding health care. However, it is important to note that this does not imply that patients should be prevented from being treated in accordance with their specific prerequisites. We merely focus here on the need of a more systematic approach to assess the appropriateness of private financing for certain services, as there are health-care services where public funding is more appropriate than private funding, just as there are many health-care services where private funding is more appropriate than public funding. For this reason the societal objective should be to seek the optimal combination of public and private funding within the public health-care system.

The tentative conceptual framework will hopefully support policymakers in accomplishing two key objectives; (i) to identify the feasibility of individual

responsibility through the characteristics of health care as commodities; and (ii) to facilitate a transparent and systematic discussion on health-care rationing through a fair deliberative procedure. Attributes 1 to 3 in our framework (sufficient knowledge, individual autonomy and positive externalities) are all connected to the specific characteristics of health care that violate crucial assumptions for a well-functioning market. These attributes allow us to identify those specific services that can be allocated through the working of market mechanisms without resulting in sub optimal outcomes due to market failures. Attribute 4, sufficient demand, is further connected to specific characteristics concerning the provision of health care, which may call for public funding in order to ensure that individuals are able to take individual responsibility. Health-care services that (for reasons other than market failures) are not available through private alternatives are unsuited for individual responsibility. The lack of these services would consequently make them high-priority candidates for inclusion in the publicly funded health-care system. In addition, policymakers also have an obligation to protect people from unbearable financial costs associated with poor health. Rationales for collective responsibility begin with some concept of fairness, usually involving the belief that no one should be denied health care due to inability to pay, or the idea that public funds should not be spent on 'pleasure seeking' rather than pain or symptom avoidance. Such beliefs about equality and fairness constitute an important basis for including the concepts of affordability and 'lifestyle enhancements' into the framework. The attributes related to them are of utmost importance for any approach exploring the feasibility of individual responsibility for financing consumption of health-care commodities.

What is the potential use for this conceptual framework? Past experiences in the Netherlands and Sweden have shown that any rationing principle that is poorly operational is doomed to be of limited use in priority setting. We hope that our conceptual framework will contribute to better operationalization of the notion of individual responsibility so that it can be of more explicit use in public policy. Experience in the Netherlands also shows that criteria intended to give a clear yes or no to funding are judged to be inappropriate. Hence, it is not our intention that the attributes, or the framework as a whole, should provide clear-cut answers. Rather, the six attributes need to be weighed against each other when exploring the feasibility for individual responsibility for health care. Considering health care as a set of economic commodities is just one element of the broader priority-setting process. Rationing will always involve conflicts between different values. But instead of obscuring such conflicts, we hope that our framework will provide a transparent and structural way to approach the inescapable issues of individual responsibility.

When formulating rationing principles at a policy level, there are two key risks: either the formulation is so tightly framed that it overrides clinical freedom and excludes health care for deserving cases, or alternatively it is too

loosely framed, which forces clinicians to ration health care on a case-to-case basis and renders the formulation useless as a support to clinical practice (Newdick, 2005). The ethical core values, such as human dignity and need, that are supposed to guide local authorities in setting health-care priorities in Sweden, seem to suffer from the latter. And although cost-effectiveness models have become consistently more intuitive and accessible over the past decade, there is still ground to cover before they will be widely accepted as a rationing principle. Since “if explicit decisions on priority setting, albeit based on strong economic evidence, are felt to be politically unacceptable they are unlikely to be implemented” (Robinson, 1999: 23). Ultimately, the political process in democratic societies will determine which services to exclude from the publicly funded health-care system. Consequently, we are faced with two alternatives: we can either ignore the fact that we can not afford everything and just let rationing take its course by default, or we can make decisions on rationing explicitly by design. This paper has provided a tentative framework to aid policymakers in conducting rationing by design, filling the gap between existing ethical principles and cost-effectiveness, by explicitly addressing the question: individual responsibility for what?

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