

8

Just Health Care in a Pluri-National Country

PHILIPPE VAN PARIJS

Justice in health care is an important issue for a number of reasons. Some of these are obvious, others less so. I shall here illustrate one of the less obvious ones by showing how the choice of a conception of justice in health care can crucially affect the conquest of a city and the survival of a country. This is not science fiction of a sort philosophers relish in concocting. This is about the fate of my own country in the last few years, today, and in the difficult years to come. Nor is it a parochial issue whose relevance is confined to a handful of anomalous corners of the world. Let us bear in mind that the world's estimated 6,000 living languages only have 211 sovereign countries to house them. Moreover, as economic globalisation tightens its grip on small and medium-sized nation-states, redistributive institutions organised entirely at the national level will become increasingly difficult to sustain, and one will have to think about how best to conceive of social justice or solidarity, *inter alia* in matters of health care, at a level that exceeds the nation-state.

8.1. HEALTH CARE CONFLICT IN A BI-NATIONAL FEDERAL STATE

Belgium was born in 1830 as a strongly unitary state on the French model, with French as the sole official language. In 1994, after a long and strenuous sequence of constitutional reforms, it became a complex federal state based on two distinct partitions of the population into three regions and into three communities, each with its own parliament and government. The regions took control over most 'territorial' powers such as public infrastructure, environmental and economic policy, while the communities were put in charge of such 'non-territorial' matters as education, culture, and (some aspects of) social policy. The three regions are Flanders, nearly 6 million inhabitants, mostly Dutch-speaking, very prosperous; Wallonia, nearly 3.5 million inhabitants, mostly French-speaking, in worse economic shape; and Brussels, the national capital, 1 million inhabitants, mostly French-speaking, the second richest region of the European Union in terms of GDP per capita but nonetheless with

a per capita income below the country-wide average, owing to over half its jobs being filled by commuters. None of the three communities coincides with any of the three regions. The Flemish community consists of all residents of Flanders, and Brussels' small Dutch-speaking minority; the German community consists of the (60,000) residents of a handful of communes in the Eastern part of Wallonia; and the French community consists of all other residents of Wallonia and of Brussels' large French-speaking majority.

Despite this comprehensive devolution, the whole of Belgium's comparatively generous welfare state, including its high-quality health care system, has always been, and so far remains at the federal level, the bulk of it being funded by proportional social security contributions levied at the same rates throughout the country. But there are reasons to believe that this situation is unstable. At about the same time as the country became federal, statistical data revealed that the Walloon population had a per capita consumption of publicly funded health care significantly higher than the Flemish population. This could be attributed in part to its demographic structure (more elderly people), and to its economic situation (more unemployment). But it was also due in part to medical habits that turned out to be more expensive in Wallonia than in Flanders. For example, more diagnostic tests were routinely performed on the basis of similar symptoms, and more specialist services were routinely used for the same pathology.¹ Unsurprisingly, once these figures were known and appropriately advertised by Flemish journalists and politicians, a feeling of injustice quickly developed among Flemings: Why should they subsidise the Walloons' more expensive 'tastes'?

When two statistically identifiable segments of a population are covered by the same publicly organised health insurance system, the existence of large differences of per capita levels of health care consumption is not necessarily a problem: the differences may simply reflect inequalities in objective health risks beyond people's individual and collective control. But there is bound to be a problem if, for given health risks, the two segments—whether defined along linguistic, professional, provincial, or any other lines—consume unequally. In the case of linguistically distinct groups, this inequality might be due to some deep-seated cultural differences between members of the two groups. More plausibly, in the present context, it may be due to the influence of institutional differences, now under the control of regional or community authorities, such as an academic training of Walloon doctors that favours a wide spectrum of diagnostic tests, or a higher ratio of specialists to general practitioners in the Walloon population. Whatever the cause of the divergence (with given objective risks), the viability of a common insurance system requires—both for efficiency and for equity reasons—that it should be neutralised. The response to the challenge presented by the disturbing statistical data is

¹ See Schokkaert and Van de Voorde (1998) for a well-documented and dispassionate analysis.

therefore straightforward, it would seem: one must tighten the monitoring of the application of the common norms, so as to ensure a more uniform interpretation (by health care organisations, doctors, and patients) of what entitlements are generated in given objective circumstances, by virtue of the centrally funded health insurance package.

The challenge, however, is deeper than what this straightforward response can handle. First of all, objective medical needs themselves may be significantly influenced by the use regions and communities are making of the powers that have already been devolved to them in areas other than health care. Careless town-planning may foster psychiatric disorders; ill-guided economic and social policy may partly account for high unemployment and the associated health hazards; sloppy environmental and traffic regulations may increase casualties; and the way schools are managed is likely to affect teenagers' smoking, drinking, and drug-taking habits. For the overall design to be fair and efficient, it is therefore not sufficient to make the health care system work in a uniform way, for given objective needs. Differences in objective needs themselves are, at least in part, the responsibility of regions or communities.

Second, quite apart from being insufficient, it is not obvious at all that the uniform application of common norms is desirable. For the three regions of the country, or more plausibly still, its two main linguistic communities, could easily develop significantly distinct conceptions of the overall share of public resources to be devoted to health care and of the specific make up of the package of services that these resources should be used to provide free of charge, or at a subsidised rate. How much, if anything, should be covered by way of dentistry, cosmetic surgery, acupuncture, fertility treatment, abortion, hospital comfort, or physiotherapy? Where does the border lie between the admissible and the murderous easing of an elderly person's death? On all these issues, there is bound to be some disagreement within any linguistic community, but distinct cultural traditions and public debates could easily generate median answers that differ markedly from one community to another.

8.2. THE DUALISM OF SOLIDARITIES

These two difficulties are inherent in the 'unitarist' response outlined above, but can be dealt with at one swoop by a coherent, principled approach which tends to be associated, in the Belgian debate, with the most radical Flemish organisations, but which can boast strong credentials, as we shall see, from the most respectable of philosophical sources. This approach, which I shall label 'dualistic' rests on a sharp dichotomy between solidarity between the members of one people, and solidarity between peoples. I shall argue against it below, but I first want to spell it out in what I believe to be its most attractive version.

According to this dualistic conception, inter-individual solidarity *within one people* can be conveniently understood along the lines of insurance behind

a veil of ignorance. In the particular case of health care, the relevant thought experiment can be phrased as follows. We accept to abstract from our particular situation among all those in which the members of our people could find themselves, and we wonder what we would insure against, and for how much, on the background of a shared conception of what counts as being ill, and what treatment ill health requires. Put differently, it can be viewed as counterfactual reciprocity: I do this for you, not because you will give me something equivalent in exchange (whether certainly or probabilistically), but because I believe I *could have been* in your position, and you in mine (since we are members of the same people), and I trust that (as a member of the same people, sharing the same conception of what counts as being ill, etc.) you would then have done for me what I now do for you. As defined by this solidarity, justice within one people is of course far more demanding, morally speaking, than actuarial fairness. But it does not reach beyond the borders of one's people, characterised in a mutually reinforcing way by identification ('I could have been her'), and by a common culture ('in matters of health care at any rate, we care about roughly the same things to roughly the same extent'). This does not mean that there is no room for solidarity *between peoples*. But instead of being opaquely camouflaged as inter-individual solidarity, it should be circumscribed to specific risks societies as such are exposed to, such as famines, floods, epidemics, and highly adverse economic conditions.

Such a sharply dualistic approach was strikingly articulated by the federation of Flemish cultural associations which vigorously launched the public debate on the partition of Belgium's welfare state in the early 1990s.² What it implies for the organisation of the health care system is clear. Rather than trying to enforce uniformity more strictly, one should rather allow each people, each linguistic community, to make its own choices, bearing of course the full financial consequences of these choices. The just organisation of health care would then require each people to determine its own guaranteed health care package, and to fund it with its own money. Both problems left unsolved by the 'unitary' approach are then easily solved. The fact that objective medical needs are affected by the use each community makes of its decentralised powers no longer offers opportunities for free riding and irresponsibility. Nor does the fact that one community may have more expensive 'tastes' with given objective needs. Moreover, this approach grants each community full freedom to develop its own vision of a just and adequate health care system. If one of the two communities is doing so badly that it qualifies as needy, solidarity across communities is called for. But this residual solidarity would henceforth cease to be exercised specifically via the health care system, and be amalgamated into a transparent general solidarity grant to the destitute community.

² See OVV (1991), and Pieters (1994) and Bertels et al. (1998) for a detailed blueprint and argument.

8.3. BREAK-UP AND RECONQUEST

If consistently and thoroughly implemented, this conception of justice in health care has dramatic consequences for the fate of Belgium, and particularly of its capital city, Brussels. To understand this, a few figures should be helpful.³ Whereas the relative sizes of the Flemish and francophone communities are about 60 and 40 per cent, respectively, their contributions to the funding of the country-wide health care system (about 1,300 euros per capita annually in 1997) are about 64 and 36 per cent and their share in total health care expenditure about 57 and 43 per cent. A corollary is that over 10 per cent of the francophones' consumption is funded by net transfers from the Flemings because of lower per capita contributions, and nearly another 6 per cent because of higher per capita spending. The entire gap between revenues per capita, and much of the somewhat smaller gap between expenditures per capita can be explained by Wallonia's weaker economic and demographic situation.

Under the 'unitary' approach of norm uniformisation, net transfers stemming from unequal incomes or from objective differences in medical needs would be left untouched, and the loss to the francophones would therefore be limited to a small fraction (attributable to their 'expensive tastes') of the 6 per cent of excess per capita consumption. Under the 'dualistic' approach, on the other hand, each community would be organising its own health care system, and the loss to the francophones would be given by the total of all current net transfers, and hence amount to nearly 16 per cent of their consumption.

Moreover, under this 'dualistic' approach, there is no good reason to stop here. What can be said about the organisation of a people's health care system can easily be generalised to its educational system, its child benefit, pension, and public assistance schemes. In all these areas, it should be up to each people to work out and implement, with its own resources, its vision of solidarity, with the total direct loss in net transfers easily reaching 5 per cent of Wallonia's GDP.⁴ Now that Belgium has long lost its colonies, has little need for an army, and has given up its currency, it is hard to see how it could survive the shock of the dismantling of its common welfare state. Or at least, the break up of the country would seem unavoidable, assuming dualists got their way, if some solution could be found for Brussels, where the two communities are tightly intertwined: the divorce will not go through, and the

³ All estimates of proportions are based on d'Alcantara (1995: 490–1), which relates to the 1990 situation, with a 20%/80% assumption about the shares of the two communities in the populations, revenues and expenditures of Brussels and with the small German community amalgamated, along with the rest of Wallonia, into the French community. Absolute magnitudes are based on the 1997 figures provided on the web site <http://belgium.fgov.be> ('*La sécurité sociale: Données statistiques et financières*'). See also Van Gompel (1998) and Docquier (ed.) (2000) for updates on net transfers.

⁴ I am here abstracting from any indirect cost, such as the loss of Walloon jobs resulting from the emigration of purchasing power across the linguistic border or the economic consequences of a dramatic fall in the funding of the education system.

168 *III: Responsibility for Health and Health Care*

bickering will linger on unless some mutually agreeable arrangement is found for the couple's child.

But precisely, the very same dualistic conception provides the theoretical underpinnings for a reconquest of Brussels by Flanders, which would elegantly (though not painlessly) settle the matter. Brussels used to be a Flemish-speaking city, and is completely surrounded by Flemish territory, but basically as result of having been the capital of a francophone state, less than 20 per cent of its current population have Flemish as their mother tongue. Moreover, it is hard to see how the 'Frenchization' of the city could fail to continue, as cheaper, safer, greener, and more Flemish suburbs are bound to exert a strong attraction on a large fraction of Brussels's shrinking Flemish minority. Yet, it can be reversed. Here is the recipe.

First implement the dualist conception of solidarity outlined above, so that each of Belgium's two main linguistic communities organises and funds at least its own health care, child benefit, and education systems. Next, rather than making membership of a community an ascriptive matter of mother tongue, let Brussels households choose, as they can now, which community they belong to, and hence which package of health insurance, schools, and child benefits they will have access to, jointly with the obligation to contribute to their funding. Making the choice of these three items a joint choice is quite natural, as education is already, for obvious reasons, devolved to the linguistic communities (though still centrally funded), and the right to child benefits (currently up to age twenty-five and centrally funded) is subjected to school or university attendance. Given the huge difference between per capita incomes in Flanders and Wallonia, the Flemish benefit-contribution package is bound to be worth far more than what the francophones can offer: the gap should reach about 2,500 euros annually for a family of four.⁵

At this sort of level, powerful financial incentives are in place for Brussels families to move over from the French to the Flemish community—especially when bearing in mind that the majority of these families, if weighted by the number of children, is of recent immigrant origin. Given the key importance of the language of schooling, and taking a number of snowball effects into account—decline and demoralisation of the French schools, return of Flemings to Brussels, etc.—the 're-Flemishization' of Brussels will then follow in the space of one or two generations, at least if enough material resources and paedagogical acumen are channelled into Dutch-language schools to help them cope with the massive

⁵ With the communities fully in charge of the funding of education, health care, and child benefits, the Flemish community could offer 250 euros per capita more than now to its members with unchanged contributions (or tax them 250 euros less with unchanged benefits and services), while the French community will have to reduce the value of its services by 400 euros per capita (or collect 400 euros more in contributions with unchanged benefits and services). Hence an annual differential of 650 euros per person, depending on which community one chooses to belong to. Estimates on d'Alcantara (1995), supplemented by the *Exposé général du budget 1998* (Bruxelles: Services du premier ministere 1997) and *Les séries statistiques* (Bruxelles: ONAFTS 1997).

influx of non-native pupils. The region of Flanders could then simply absorb the city-region of Brussels, which it (oddly but, it would then turn out, quite aptly) chose as its official capital when Belgium became a federal state. And the decisive condition would then be satisfied for Belgium itself to wither away.

8.4. THE LAW OF PEOPLES

This completes my illustrative demonstration of how a conception of justice, and particularly a conception of justice in the area of health care, can unexpectedly prove to matter greatly to the reconquest of a city, and the fate of a country. While much in the example is idiosyncratic, the challenge it illustrates cannot easily be dismissed as having only local or anecdotal interest. As pointed out above, pluri-national polities are the rule rather than the exception, and increasingly so. Moreover, the dualistic conception which did much of the work in the above demonstration cannot be reduced to an ad hoc construct advertised by a handful of organisations in a tiny portion of the world in order to rationalise their self-interested demands. For the twentieth century's most influential political philosopher is defending a dualistic conception of social justice which bears far more than a superficial resemblance to it. John Rawls's *Law of Peoples* (1999) rests on a dichotomy between two 'original positions'—one with representatives of the members of one people, and one with representatives of the various peoples—which closely parallels the two solidarities outlined above. And it generates distributive outcomes—the difference principle (or some other liberal-egalitarian distributive principle) within each people versus the far less demanding duty of assistance between peoples in case one of them became 'burdened' by adverse circumstances—which closely parallel those following from the dualism of solidarities—an elaborate system of institutionalised inter-individual transfers within each people versus an explicit, transparent grant to the government of a needy people.

A closer examination—which I shall not undertake here (see Rawls and Van Parijs 2003)—would no doubt come up with some significant differences, but these would emerge on a firmly common background, constitutive of what I am here calling a dualistic approach: a sharp distinction needs to be made, when discussing social justice in general, and justice in health care in particular, between those persons whom it makes sense to imagine sitting in the same original position, putting themselves in the others' shoes, reaching an agreement, behind a self-imposed veil of ignorance, on what to insure for, and what not, and those who belong to different peoples, and are therefore only indirectly linked through the far weaker duty of solidarity which connects their respective peoples. Thus, quite apart from its intuitive plausibility, the dualistic view articulated by the federation of Flemish cultural organisations turns out to be endorsed by John Rawls himself.

And yet, it should be resisted. This is not because there is something outrageous about the death of a country—a mere artefact which there is no need

to revere as a fetish—or about the linguistic reconquest of a city—no more objectionable than its prior conquest, in the course of the last couple of centuries, through the social and economic pressure to learn a more prestigious language. My firm conviction that the dualistic view should be resisted has two different sources. First, as a citizen of a pluri-national state whose survival is at risk, and at the same time of a multinational political entity—the European Union—which is undeniably more than a confederation of states, yet has no professed intention or objective prospect of becoming one country or one people—I cannot help finding the notion of ‘people’ far too contingent, too fragile, too much a matter of degree, to allow a conception of justice to be structured by a dichotomy which gives it a central role. Second, although I fully recognise the difficulty, and in most cases the undesirability, of developing a public health insurance system across the borders of populations with different languages, and hence, in all likelihood, diverging public debates, I also feel that it would be a serious regression if the relatively generous inter-individual transfer system that currently exists across linguistic borders in pluri-national welfare states such as those of Belgium or Canada were to be dismantled, and that it would be a bad, thing, as far as justice is concerned, if no similar system could be institutionalised in countries in which it does not yet exist.

Yet, the intuitions which inspire this resistance can be naturally accommodated within an approach that would remain, in a general sense, ‘Rawlsian’, that is, not only liberal-egalitarian, but also concerned to respect the prerogative of different ‘peoples’ to design their solidarity systems, and in particular their health care systems, in accordance with their views as to what an illness is, for example, and what treatment it requires. There is no doubt more than one way of trying to articulate a ‘Rawlsian’ resistance in this sense. I shall present one, which directly follows from the particular liberal-egalitarian conception of social justice I tried to defend in *Real Freedom for All*, thus seizing this opportunity to spell out the latter’s central implications for the just allocation of health care, and to test its plausibility in this area.

8.5. MAXIMIN GIFTS, AND UNDOMINATED DIVERSITY

The conception of social justice as ‘real freedom for all’ essentially consists in the combination of two simple ideas, each of which I find very appealing, though unacceptable if not supplemented by the other.⁶ The first of these ideas is the maximin distribution of gifts. Whether deliberately or unwittingly, whether structurally or randomly, countless gifts are made to us in the course of our lives, mainly today through the jobs and other market opportunities which our talents and other forms of luck give us very unequal access to. There is no reason to expect the spontaneous distribution of these gifts to be fair. Fairness does not

⁶ For the sake of brevity, I am here leaving out a third simple idea—universal self ownership—which operates as a prior constraint on the other two (see Van Parijs 1995: chapter 1).

mean that we should all receive identical, or equally valuable gifts. But it does require—this is the first simple idea—that the value of the gifts received by the person who receives least should be sustainably maximised. This criterion naturally leads in a market society to giving each an unconditional cash endowment at the highest per capita level that can be sustained through predictable taxation. This endowment could conceivably be given in the form of a one-off payment that could be turned into a regular payment by those who so wish—higher for men than for women, though, because of the latter's higher life expectancy. I favour instead a regular instalment over people's lifetime, equal for all at a given age.⁷ One way of motivating this preference consists in assuming that spreading the income guarantee over their whole lifetimes in this fashion is what people would do if asked to make up their minds *ex ante*, with full knowledge of the consequences of every option but without knowing which statistical category (man or woman, etc.) they belong to.⁸ Another rationale, metaphysically more demanding perhaps, rests on the claim that later selves need to be protected against earlier ones: a just society cannot countenance destitute elderly people who owe their destitution to their squandering youth.

This first simple idea—the maximin distribution of gifts—fits my considered moral judgement quite well, or rather would do so if one could disregard handicaps or, more broadly, significant differences in capacities that are not, or not fully, reflected in unequal market rewards. This is where the second simple idea kicks in. It is called for to handle cases in which the assumption of equal talents is far off the mark. If we have unequal capacities, if some of us are handicapped as a result of genetic defects, accidents at birth, unfavourable family environments, etc. justice cannot be achieved by giving all an equal cash grant, be it at the highest sustainable level. It requires a more targeted compensation to the less well endowed. According to what criterion? I propose *undominated diversity*.⁹ Let us define a person's comprehensive endowment as the set of all the external resources he or she is given, and of all the (internal) capacities he or she is endowed with. Undominated diversity is satisfied if for any two members A and B of the community considered, there is at least one member of the community who prefers A's comprehensive endowment over B's, and at least one who prefers B's over A's. In other words, undominated diversity

⁷ I am here stating dogmatically a sequence of claims for which I argue in Van Parijs (1995). Chapter 2, in particular, defends the idea of a regular payment or basic income—James Tobin's 'demogrant', James Meade's 'social dividend'—against the related idea of a basic endowment, which can be traced back to Thomas Paine (1796) and has been recently revived by Ackerman and Alstott (1999). See Van Parijs et al. (2001) for a recent discussion.

⁸ Daniels (1996: 262) argues along the same line on the basis of his 'prudential lifespan account' (to which I return below): 'the prudent course of action would be to allocate their (the planners') fair share in such a way that their standard of living would remain roughly equal over the life-span'.

⁹ The criterion is vindicated at length, and defended against its rivals, in chapter 3 of Van Parijs (1995). It constitutes a generalisation and reinterpretation of a notion put forward by Bruce Ackerman (1980) in connection with liberal genetic engineering.

amounts to the absence of a unanimous preference among endowments within the community. If instead the existing diversity is 'dominated', say because of a unanimous preference for A's comprehensive endowment over B's, one must channel external resources from A to B up to the point when there is at least one person who prefers B's comprehensive endowment to A's.

To convey the underlying intuition, I shall briefly sketch four perspectives from which this criterion can be motivated. First, some may find appealing the idea that for redistribution from A to B to be justified, all one needs is that a majority should prefer A's comprehensive endowment to B's. But this can mean requiring a transfer from A to B despite the fact that both A and B find A's endowment worse than B's. For those who want to rule out this possibility while sticking to a majoritarian approach, undominated diversity is a natural criterion to adopt.

Others may instead be attracted by the notion of envy-freeness: a distribution of endowments is just if no one envies anyone else's endowment. But this criterion is generally unsatisfiable if people possess at the same time different talents and different tastes. For those who are bothered by this limit, while wishing to stick as much as possible to the envy-freeness approach, undominated diversity is again a natural option. For undominated diversity is nothing but *potential* envy-freeness: saying that undominated diversity obtains is equivalent to saying that, for each member of any pair (A, B) of people in the community, there exists at least one preference schedule actually held in the community such that, were A to adopt it, he or she would not envy B's endowment, and there also exists at least one such schedule such that, were B to adopt it, he or she would not envy A's endowment.¹⁰

Others still may be tempted by a conception of justice as equality of welfare, or at least as equality of potential welfare or of opportunity for welfare. But whether for epistemic reasons or for deeper ethical reasons, they may become persuaded that welfare levels are incommensurable across individuals. They then have to reduce their ambition from a complete ordering to a very partial ordering corresponding to the intersection of all individual orderings. This is exactly undominated diversity.

Last but not least, among those who believe for other reasons—typically, the treatment of expensive tastes and adaptive preferences—that equality of welfare or of potential welfare is not even a *prima facie* characterisation of social justice, there is a temptation to focus exclusively on the distribution of goods or external resources. But such an exclusive focus would overlook unjust inequalities in people's capacity to turn goods into valuable functionings. The pursuit of justice rather consists, at least in part, in the equalisation of people's basic capabilities. But what counts as a basic capability, and what tradeoffs, if any, can be allowed for between different levels of different basic capabilities?

¹⁰ See Fleurbaey (1994, 1995) and the appendix to Van Parijs (1995: chapter 3) for more formal discussions of various ways of weakening envy-freeness.

One possible answer rests on a perfectionistic conception of the nature of human beings and their needs. But there is also a liberal, nonperfectionistic answer: undominated diversity.¹¹

To work out the most plausible version of the criterion of undominated diversity, some tightening of the formulation is required, at least in the form of a restriction of relevant preferences to well informed or 'reasonable' ones, and some loosening is required too, for example, to exclude redistribution that would turn out to be counterproductive because of adverse incentive effects (the analogue to preferring leximin over strict equality for a one-dimensional variable). Thus trimmed and tuned, the criterion easily justifies the targeted redistribution of resources for the benefit of specific categories of 'disabled' people. This redistribution may take the form of handicap-tested cash transfers, but also of collective investments in special schools, adapted technology, handicap-friendly public infrastructure, or even of the spreading of a general ethos of tactful help: being blind can be quite a different experience depending on whether one lives in a society in which everyone looks away or drives past when a blind person is struggling to cross a street, and in one in which she can always count on a helping arm.

In its most defensible specification, undominated diversity remains a very weak criterion of equality. My firm intuitions about social justice are far too egalitarian to find it attractive as a full characterisation of what justice requires. But I find it exceedingly appealing if it is consistently combined with the first simple idea, more specifically if it is made a constraint on the sustainable maximisation of the external endowment that must be unconditionally granted to all in order to maximin what we are given.

8.6. HEALTH INSURANCE AS A COMPONENT OF THE BASIC ENDOWMENT

What relevance does all this have for just health care? I mentioned that the maximin of gifts naturally leads to an unconditional cash basic income. But the presumption in favour of an all-cash endowment can easily be overridden in favour of at least a modest in-kind component. Trivially, one of the most vital gifts we receive every second or two is the air we breathe, and nobody would find it a particularly clever idea to fit an oxygen meter onto our noses, and make us pay a fee for each gallon we inhale (even though some market freak might well have suggested that this would be the efficient thing to do). A less facile but no less persuasive case can be made for a health-insurance package as a further in-kind component. The argument for constraining part of the endowment in this way can be based on the existence of various external benefits of making health insurance obligatory for all. This may have to do, for example, with adverse selection problems that hamper voluntary schemes,

¹¹ See, for example, Sen (1985); Van Parijs (1990); and Sen (1990) on the connection.

with public good aspects in the control of epidemics, and with administrative advantages in the treatment of emergencies. The case can also rest, in a mildly paternalistic vein, on the plausible assumption that anyone fully aware of the probability of health problems, their costs and other consequences, would devote some of her basic income to a basic health insurance package. The guiding question should be: supposing I did not know anything about my own specific risks of needing any particular form of health care, while knowing everything about the probabilities of the various risks, their consequences, and the cost of the various available cures, what types of treatment would I want to be covered, and to what extent, by an insurance scheme to which everyone would be obliged to subscribe, all this bearing in mind that its cost will be deducted from the basic income given to all.¹² Under reasonable assumptions about risk aversion, the overall level of the highest sustainable basic income, and the degree to which people in a given society have a shared conception of what health is, and what illness requires, a substantial basic health insurance package can be expected to be justified in this way.

What form should the health insurance package, thus justified, take? It could in principle take the form of an undiminished cash benefit with an obligation to insure or, at the other extreme, of the direct free provision of care to all by public sector employees. Or it could take a number of intermediate forms such as a standard insurance package that directly pays private care providers or reimburses the patients for at least part of the expenses. Should it be means-tested or universal? Just as a cash basic income could be given in the form of a negative income tax, free or subsidised access to health care could either be granted to all irrespective of incomes, or phased out as household income increases. From Tawney ('A policy for the poor is a poor policy') to Atkinson (1998), the pitfalls of means-testing have often been emphasised (stigma, poverty trap, rate of take up, dynamics of political support). The resulting strong presumption in favour of universality can conceivably be overridden, however, either because of an inefficient tax system that fails to claw back the benefits granted to the better endowed or because of the political weight of the persistent illusion that a policy concentrating on the poor is bound to be more cost-effective.

This forms the background on which undominated diversity can now operate. But to see how it does, it is essential to clarify the relevant time scale. Handicaps demanding targeted transfers can be present at birth, but also appear in the course of a person's life. To assess whether any of them is dominated, people's endowments are to be compared over their entire lives, not at the particular stages of life they happen to be. This is why undominated diversity does not mandate massive transfers to the very old. But since one cannot wait for someone's life to be completed to decide whether any targeted transfer

¹² Just as the spreading of the basic endowment over the lifespan, this allocation of part of it to a specific health care package is justified by a 'prudential lifespan account' of a sort similar to Norman Daniels's (1988, 1996).

should be made to or from her, one will constantly have to operate on the basis of presumptive anticipations. Becoming crippled or blind or indeed dying at age five will not be assessed in the same way, by the standards of undominated diversity, as being similarly affected at age ninety. Through this path, undominated diversity justifies an age-sensitive allocation of health care resources which discards the irresponsible or hypocritical 'Life is sacred' or 'Health has no price', without implying any instrumentalistic commitment to the maximisation of aggregate welfare, let alone of economic performance.

Whether existing from birth or arising from some later accident, disabilities of all sorts can be expected to be alleviated by the health care package justified as part of everyone's basic endowment. The extent of dominated diversity will therefore be substantially reduced, not only relative to a situation in which there is no redistribution whatever, but also relative to one in which the whole of the highest sustainable basic income takes the form of a uniform cash grant. But it is unlikely to have vanished altogether. Even with the correction resulting from care which has seemed cost-effective enough to be made part of the basic package, it is still likely that what can be presumed about the make up of some people's lifetime endowments will make these worse, in everyone's eyes, than some other people's, and some targeted distribution, over and above the basic income, will therefore be mandated.¹³ As mentioned before, this targeted redistribution need not take a cash form, and may quite plausibly take the form of medical care focused on a specific condition.

Of course, working out the concrete implications of the thought experiment that defines undominated diversity, just as working out those of the thought experiment that specifies the basic health insurance package, needs to rely on countless empirical conjectures, and will never supply more than approximate guidance. But the conjunction of both provides, I believe, a coherent and plausible framework which can guide the identification of relevant arguments and sensible policies. Rather than trying to argue why this framework may prove more satisfactory than those proposed, in a broadly similar spirit, by Norman Daniels (1985, 1988); Erik Rakowski (1991); Ronald Dworkin (1993, 1994); and others, I now return, on the background it provides, to the issue of just health care in a culturally divided society.

8.7. JUST HEALTH CARE IN CULTURALLY DIVIDED SOCIETIES

Let us first consider the general question of how cultural diversity in matters of health care affects the operation of the framework just sketched. Suppose,

¹³ The more generous and medically effective the basic health insurance package, the smaller the need for targeted transfers. And the less targeted redistribution is needed, the more generous the basic endowment can be, and hence also its health insurance component. As economic prosperity, medical efficiency and/or cultural diversity increase, one may therefore expect the demands of justice to require less and less targeted transfers. (On the other hand, better genetic diagnosis, for example, may make it possible, or easier to detect cases of undominated diversity which would otherwise have gone uncompensated.)

176 *III: Responsibility for Health and Health Care*

for example, that one segment of the society concerned regards biological parenthood as an essential part of a successful life, whereas the other does not. It is clear that both of the thought experiments introduced above will yield different results, depending on whether they are performed at the level of the society as a whole or within each of its two segments separately. Some fertility treatments will be part of the basic package in one of these groups, whereas it will not be (or only at a lower level) in the society as a whole. Furthermore, persistent infertility will turn out to be a handicap, to be compensated by appropriate means, in the former context, but not in the latter, where undominated diversity will therefore be easier to satisfy. This example illustrates the following general point: the more culturally diverse the society concerned, the more meagre the health care package that will be justified, either as part of everyone's endowment, or as part of a targeted transfer to those members of the society who can be identified as handicapped.¹⁴ At the limit, extremely high levels of cultural diversity would shrink the health care package into insignificance, and secure undominated diversity even in the absence of any transfer. Hence, keeping culturally different parts of a society together blocks the just institutionalisation of more generous health care systems, while splitting a society along cultural lines would enable each part to justly develop its own distinct and more generous system.

Yet, this shrinking of the health care package does not translate into a corresponding shrinking of the overall level of redistribution, as whatever is no longer redistributed in a targeted form is now to be redistributed to all, while whatever was redistributed in kind must now be redistributed in cash.¹⁵ The crucial point is that while the thought experiments which specify the just pattern of in-kind provision and the demands of undominated diversity require some degree of cultural homogeneity to have any bite, the one which underlies the justification of a basic income does not. To justify strong redistributive demands, it does not require that we should be homogeneous in terms of what we care about in life, but only that we should view ourselves as rival recipients of gifts, which we are unequally positioned to capture for reasons we recognise

¹⁴ Here is another example, which shows at the same time how broadly undominated diversity can be interpreted. In various countries, some financial aid is given to people who have a close relative (parent, partner, child) requiring intensive care and feel morally obliged to sacrifice some or all of their professional activities in order to look after that relative—sometimes at the cost of great material hardship. In a society in which we all feel this moral obligation, undominated diversity can justify this if we extend the understanding of a person's endowment to cover features of his or her situation, such as the fact that he or she has a badly handicapped child. But it is enough for some people to sincerely not care, to feel no such obligation, for undominated diversity to lose its bite. The more culturally diverse the society, the more likely this is to happen and the poorer this scheme's prospect of being justified.

¹⁵ The former shift does entail a small fall in net redistribution, as contributors are now also among the beneficiaries. The latter shift does not. Admittedly, giving part of the basic income in the form of health care may boost its highest sustainable level (e.g. because of its effect on the spreading of epidemics), but the components of the package that could plausibly produce such an effect would not cease to be justified as a result of increased cultural diversity.

are arbitrary. The chasing of the same jobs, outlets, inputs or investments, exposure to the same externalities, the imposition of political borders which protect the living standards of some, and prevent others from improving their fates, all this contributes to making such a picture of ourselves compelling, and hence also the need to secure a fair distribution of the value of this wide variety of gifts. How much of what she values each person will be guaranteed access to depends on the price structure, and hence on the overall pattern of preferences, including society's cultural constellation. But whatever diversity obtains, there is no reason to expect the real value of the highest sustainable basic income to shrink as a result of greater diversity.¹⁶

Against this background, it is certainly conceivable to give culturally more homogeneous segments of a society the option of working out their own distinct health care system. One convenient way of doing so, assuming that the level of coverage (as distinct from the pattern of care that is being covered) is about the same in the various segments, consists in giving the government of each of these segments a centrally funded capitation grant with which it can directly finance or indirectly reimburse the services the relevant thought experiments justify providing. Applied to the Belgian situation described at the start, this conception would be sympathetic to a community's desire to have its distinct health care system, if it feels prevented from designing it as it wishes, owing to the cultural diversity generated by linguistic distinctness, and the associated separation of public debates. But there is no reason why a poorer community should have to fund the whole of its health care system 'with its own money', except to the extent that it wishes to devote to health care a larger per capita share of total resources than the other communities. This fact may considerably reduce the attraction of a separate system for those whose main objective is not to make room for autonomy but to curtail net transfers. Yet, it may still present enough advantages to offset any economies of scale that derive from the existence of a joint system, and all the transitional and permanent administrative complications of a separation.

Even if it spreads to other sectors of the welfare state, a separation of this sort would have an impact on the fate of Belgium and its capital very different from the one sketched above in connection with the 'dualistic' conception. First, a strong federal state would of course still be essential to secure a fair distribution of resources, by collecting taxes (or social security contributions) throughout the country according to people's ability to pay throughout the country, and allocating the revenues to each community according to the size of its population, possibly weighted, for example, by the relative levels of medical expenditure for the various age groups, so as to capture at least this aspect of the 'objective' health risks. Second, the mechanism for a linguistic reconquest of Brussels would be switched off. For even if every Brussels

¹⁶ I am here abstracting from the possible effect of cultural diversity on general economic performance as discussed for example by Alesina and La Ferrara (2003).

household were still made to choose between the health-care-and-child-benefit-and-education systems of the two communities, the small difference in the financial advantage of joining one rather than the other would lack the muscle needed to precipitate a massive conversion to the Flemish community.¹⁷

Even more important are two further differences with the 'dualistic' scenario. First, now that the project of turning Belgium into a single (francophone) nation has long been shelved, and that a full recognition of the two languages has gradually led the two linguistic communities and their public debates to drift apart, the dualist approach justifies a dismantling of Belgium's trans-regional transfer system. By contrast, according to the alternative approach just sketched, this system does not need to be dismantled but only reconfigured in a lump-sum direction, so as to prevent the autonomy granted to each community from giving rise to unfair compensation and inefficient incentives. Something closely analogous to what would emerge from such a reconfiguration—rather than an extension of national solidarity onto a higher scale through the construction of a European welfare state—is also exactly what is needed in such larger multinational polities as the European Union.

Second, while recognising that more homogeneous polities can and must go for a more refined solidarity, this alternative approach does not ascribe to the notion of a 'people' the momentous importance it is given by the dualist approach. As soon as significant potential mobility and other interdependencies exist, the demand for a fair distribution of external resources extends across the borders of states and cultural communities. It calls for the preservation and development of institutions for collecting, across these borders, a significant share of resources which would otherwise be appropriated by some because of the luck of being born within particular borders, of speaking a particular language, of possessing particular marketable talents, or of having acquired the right skill at the right time, etc. And it calls for an allocation of these centrally collected resources either directly to individuals or to the more decentralised authorities in charge of education and health systems. At these more local levels, cultural homogeneity should durably remain greater, especially if political authorities have the power and will to enforce the adoption of the local language by anyone wishing to permanently settle within the borders of its territory.¹⁸ And because of this greater homogeneity, justice will

¹⁷ Allocating people who share the same territory to tightly separate health care and education systems may be undesirable for other reasons. However mild, this is a form of permanent 'apartheid' (unlike the temporary one involved in the reconquest scenario) which hampers the people's ability to work out and realise a coherent social project with an unavoidable territorial dimension. For this and other reasons, the sort of federalism that is needed to durably accommodate the autonomy of distinct peoples within one country is of the territorial type, rather than of the 'personal' type imagined in Karl Renner's (1918) pioneering attempt to reconcile national diversity and democracy, and very partially implemented in Belgium's federalism of Communities.

¹⁸ Possibly at a heavy and increasing cost to themselves (see Van Parijs 2000).

allow at this level—indeed mandate—more generous in-kind provision and more targeted distribution.

This is what I meant by a ‘Rawlsian’ approach—not only liberal-egalitarian but also ‘peoples-friendly’—which neither makes a sharp dichotomy between solidarity within one people and solidarity across peoples, nor fosters the dismantling of existing transfer systems across the borders of peoples. The adoption of this alternative account requires one not to think about health care systems, and the other aspects of our welfare states, exclusively in terms of ‘solidarity’, fundamentally understood as compensation for a (counterfactual) risk, and conceivably formulated in terms of some original-position-type thought experiment. The alternative account does retain something of this notion, mainly under the thin guise of undominated diversity. But the fact that the latter must operate on the background of a fair distribution of external resources profoundly changes the overall picture—and secures a sound normative basis for the defence, reform, and development of generous redistribution schemes in an increasingly globalised world.

References

- Ackerman, Bruce A. and Anne Alstott (1999). *The Stakeholder Society*. New Haven: Yale University Press.
- (1980). *Social Justice in the Liberal State*. New Haven and London: Yale University Press.
- Alesina, Alberto and Eliana La Ferrara (2003). *Ethnic Diversity and Economic Performance*; Harvard University: Department of Economics.
- Atkinson, Anthony B. (1998). *Poverty in Europe*. Oxford: Blackwell.
- Bertels, Jan, Dany Pieters, Paul Schoukens, and Steven Vansteenkiste (1997). *De Vlaamse Sociale Zekerheid in 101 vragen en antwoorden*. Leuven: Acco.
- d’Alcantara, Gonzalez (1995). ‘Interregionale verschillen’, in Marc Despontin, and Marc Jegers (eds.), *De sociale zekerheid verzekerd?* Brussels: VUB Press, pp. 485–507.
- Daniels, Norman (1985). *Just Health Care*. Cambridge: Cambridge University Press.
- (1988). *Am I My Parents’ Keeper? An Essay on Justice Between the Young and the Old*. Oxford: Oxford University Press.
- (1996). ‘The Prudential Lifespan Account of Justice Across Generations’, in N. Daniels (ed.), *Justice and Justification*. Cambridge: Cambridge University Press, pp. 257–83.
- Docquier, Frédéric (ed.) (1999). *La Solidarité entre régions. Bilan et perspectives*. Bruxelles: De Boeck Université.
- Dworkin, Ronald (1993). ‘Justice in the Distribution of Health Care’, *McGill Law Journal*, 38: 883–98.
- (1994). ‘Will Clinton’s Plan Be Fair?’, *New York Review of Books*, 13 January 1994: 20–25.
- Fleurbaey, Marc (1994). ‘L’Absence d’envie dans une problématique post-welfariste’, *Recherches économiques de Louvain*, 60(1): 9–42.

- Fleurbaey, Marc (1995). 'Three Solutions for the Compensation Problem', *Journal of Economic Theory*, 65: 505–21.
- OVV (1991). 'Standpunt: Sociale zekerheid, een niet-federale bevoegdheid', Brussels: Overlegcentrum voor Vlaamse Verenigingen, October 1991: 6. (French translation: 'La sécurité sociale: une compétence non fédérale', *La Revue nouvelle* 11, 1993: 65–8.)
- Paine, Thomas (1796). 'Agrarian Justice', in P. F. Foner (ed.), *The Life and Major Writings of Thomas Paine*. Secaucus, NJ: Citadel Press, 1974, pp. 605–23.
- Pieters, Danny (1994). *Federalisme voor onze sociale zekerheid*. Leuven: Acco.
- Rakowski, Eric (1991). *Equal Justice*. Oxford: Oxford University Press.
- Rawls, John (1999). *The Law of Peoples*. Cambridge, MA: Harvard University Press.
- and Philippe Van Parijs (2003). 'Three letters on *The Law of Peoples* and the European Union', *Autone de Rawls*, special issue of *Revue de philosophie économique*, 8: 7–20.
- Renner, Karl (1918). *Das Selbstbestimmungsrecht der Nationen, in besonderer Anwendung auf Oesterreich*. Leipzig and Wien: Franz Deuticke.
- Schokkaert, Erik and Carine Van de Voorde (1998). 'Interregionale financieringsstromen, defederalisering en solidariteit in de Belgische ziekteverzekering', *Acta Hospitalia*, 4: 63–81.
- Sen, Amartya (1985). *Commodities and Capabilities*. Amsterdam: North-Holland.
- (1990). 'Welfare, Freedom and Social Choice: A Reply', *Alternatives to Welfarism. Essays in Honour of Amartya Sen*, special issue of *Recherches Economiques de Louvain*, 56: 451–86.
- Van Gompel, Johan (1998). 'Interregionale financiële stromen in België herbekeken', *KuLeuven*, December 1998.
- Van Parijs, Philippe (1990). 'Equal Endowments as Undominated Diversity', *Alternatives to Welfarism. Essays in Honour of Amartya Sen*, special issue of *Recherches Economiques de Louvain* 56: 327–56.
- (1995). *Real Freedom for All. What (if anything) Can Justify Capitalism?* Oxford: Oxford University Press.
- (2000). 'The Ground Floor of the World. On the Socio-Economic Consequences of Linguistic Globalization', *International Political Science Review*, 21(2), 2000: 217–33.
- et al. (2001). *What's Wrong with a Free Lunch?* Boston: Beacon Press.