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Welfarism or Non-Welfarism? Public Preferences for Willingness to Pay Versus Health Maximisation

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TABLE OF CONTENTS

LIST OF TABLES

ABSTRACT

We distinguish between different forms of welfarism and non-welfarism, along three dimensions: "self-motivation", "social goal", and "role of government". The paper then reports the results of a survey of the "meta-preferences" of the Australian public concerning the principles that should govern priority setting in health care. Of 743 respondents, 77.4 per cent thought that resources should be allocated on the basis of health outcomes (non-welfarism), whereas only 11.6 per cent thought that priorities should reflect individuals' preferences as stated through willingness to pay (welfarism).

The Discussion section considers three arguments supporting WTP: first, that it is the "theoretically correct" method for valuing health effects due to its foundation in welfare economics; second, that it is the most flexible technique for evaluating health services, as it is able to include a variety of factors in addition to health that are important to individuals; and third, that it places a dollar value on life and quality of life, which is necessary if allocative efficiency is to be achieved. We argue that these arguments for individual WTP are unpersuasive.

Welfarism or Non-Welfarism? Public Preferences for Willingness to Pay Versus Health Maximisation

1. Introduction

Recent literature has reflected a renewed interest in Cost-Benefit Analysis (CBA) and the use of Willingness to Pay (WTP) techniques to place a dollar value on health care programmes, or on the health outcomes provided in terms of, for example, Quality-Adjusted Life Years (QALYs) or Disability-Adjusted Life Years (DALYs) (Donaldson, Mapp et al. 1996; Bala, Wood et al. 1998; Olsen and Donaldson 1998; Ryan 1998; Birch, Gafni et al. 1999; Olsen and Smith 2001; Phillips, Maddala et al. 2002; Chang, Kauf et al. 2003; Parks, Balkrishnan et al. 2003; Penrod, Fautrel et al. 2003). Some economists argue that willingness to pay is the "theoretically correct" or "conceptually appropriate" method for valuing health effects, and therefore superior to health-based measures such as QALYs or DALYs. However, there have been no studies that have explicitly asked the public which method *they* would prefer to apply as an aid for setting priorities. The present paper aims to (partly) fill that gap. In particular, it is concerned with the principles that decision-makers (and, in particular, governments) should adopt when they prioritise alternative health programmes. The evaluation of such principles is different from the evaluation of health programmes. To underscore this difference we refer to the preferences for alternative ethical principles as "meta-preferences".

The paper commences with a description of the normative theories that can be grouped under the headings of "welfarism" and "non-welfarism". We argue that the literature comparing and contrasting these categories – or families – of theories generally oversimplifies the possible theoretical variants, and that the framework implied in the literature needs to be expanded. After this preliminary discussion, the paper reports the results of a survey of the meta-preferences of the Australian public. The survey is predicated upon the assumption that members of the public can comprehend the principles of welfarism and non-welfarism as they apply to health sector objectives: the (welfarist) WTP criterion and the (non-welfarist) criterion of health per se as the maximand in the social welfare function. Implicitly, the study seeks to determine whether there is support for the sovereignty of direct population – qua consumer – preferences (i.e. welfarism), or whether, alternatively, citizens sometimes prefer their elected officials to override public preferences in the interests of some other social objective, such as maximising health (i.e. non-welfarism). The main hypothesis is that orthodox welfarism is preferred to health maximising non-welfarism. In other words, we investigated the "meta-question" of whether those surveyed thought that health care provided at public expense should be aimed at maximising utility or, alternatively, maximising health.

2. Welfarism, Non-Welfarism and Extra-Welfarism

As defined by Hurley, "Welfarism is the proposition that the 'goodness' of any situation … be judged solely on the basis of the utility levels attained by individuals in that situation. It excludes all non-utility aspects of the situation" (Hurley 2000, pp. 60-61). For the purposes of the present paper, "non-welfarism" is defined as the broad class of theories that reject some or all of the basic

tenets of welfarism. Included in the class of non-welfarist theories then are those referred to in the literature as "extra-welfarist".

Table 1 distinguishes welfarism from non-welfarism along three dimensions: "self-motivation", "social goal", and "role of government". These dimensions are largely independent of one another and variations within them characterise different forms of welfarism and non-welfarism. Under "welfarism", for example, the primary personal motivation ("self-motivation") is utility maximisation 1(a). However, individuals may seek to maximise their own utility in a (i) "selfish" or (ii) "selfless" way. That is, individuals may have a preference for – they may obtain satisfaction from – outcomes that benefit themselves, with any benefit to others being an incidental matter. Alternatively, individuals may have a preference for outcomes that benefit others. Some people gain pleasure from helping others and suffer personally when others suffer (Edgeworth 1881; Smith 1930; Hume 1975; Sen 1976).

Table 1: Welfarist and Non-Welfarist Meta-Preferences

<table>
<tr><td>Meta-preferences</td><td colspan="2">Welfarism</td><td colspan="4">Non-Welfarism</td></tr>
<tr><td rowspan="2">1. Self-Motivation</td><td colspan="2">(a) Utility Maximisation</td><td colspan="2">(b) Utility Maximisation</td><td colspan="2" rowspan="2">(c) Self-sacrifice (Duty, Religious Rule, etc)</td></tr>
<tr><td>(i) Selfish</td><td>(ii) Selfless</td><td>(i) Selfish</td><td>(ii) Selfless</td></tr>
<tr><td>2. Social Goal</td><td colspan="2">(a) Function of Utility – e.g. Utility Maximisation</td><td>(b) Health Maximisation</td><td>(c) Utility Maximisation + Other</td><td>(d) Other (e.g. Capabilities)</td><td>(e) Other + Health Maximisation &/or Utility Maximisation</td></tr>
<tr><td rowspan="3">3. Role of Government</td><td colspan="6">(a) Coercion</td></tr>
<tr><td colspan="6">(b) Information & Correction</td></tr>
<tr><td colspan="6">(c) Minimal</td></tr>
<tr><td rowspan="5">Combinations</td><td colspan="2">Selfish, Coercive 1a(i), 2a, 3a</td><td colspan="4">Health Maximisation 1b, 2b, 3a/b</td></tr>
<tr><td colspan="2">Selfless, Coercive 1a(ii), 2a, 3a</td><td colspan="4">Procedural 1b, 2c, 3a/b</td></tr>
<tr><td colspan="2">Liberal (Orthodoxy) 1a, 2a, 3b</td><td colspan="4">Extra-Welfarist 1b, 2e, 3a/b</td></tr>
<tr><td colspan="2">Libertarian 1a, 2a, 3c</td><td colspan="4">Self-sacrificing 1c</td></tr>
<tr><td colspan="2"></td><td colspan="4">Libertarian 1b, 3c</td></tr>
</table>

Continuing the focus on self-motivation, non-welfarist theories need not deny that individuals are motivated to maximise their own utility 1(b) (i and ii) in certain contexts. For example, utility maximisation may be a motivation in daily life, but in social contexts, where issues of fairness arise, non-welfarist theories allow the possibility of self-sacrifice 1(c). The latter sort of behaviour involves no pay-off for the self-sacrificing individual, or, if it does, the pay-off is not the reason for the sacrifice. In this sense it is counter-preferential. Sen refers to this as "commitment" (Sen 1976, pp. 326-9; Sen 2005). Particular motivations may include duties to family, friends, or country, adherence to a religious or ethical view, or the acceptance of a particular social role. (Of

course, it is a controversial matter whether commitment exists, or whether all purported instances of commitment are really examples of disguised self-interest or reasoning failure.)

By definition, welfarism is a view about social welfare rather than self-motivation. It states that social welfare is a function solely of individual utilities. In principle, therefore, the following case is possible: social welfare is a function of individual utilities, but individuals do not, themselves, exclusively seek to maximise utility. Similarly, a non-welfarist may concede that individuals seek to maximise their utility exclusively, and yet maintain that social welfare is not a function of individual utilities. It is not perverse to maintain that individuals seek to maximise their utility but that a community must take account of broader issues including, for example, the functionings and capabilities addressed by Sen (Sen 1993). These possibilities are not discussed further here.

Sen is a well-known critic of welfarism. He notes that individuals with disabilities often adjust their expectations down - they accommodate themselves to their condition - and, since well-being is largely determined by a person's situation relative to their expectations, they may have relatively high utility levels (Sen 1987). But the fact that a person has learned to live with adversity should not mean that they do not have a legitimate claim for special consideration (Menzel, Dolan et al. 2002). Rather than concentrate on utility (or primary goods, as Rawls advocated (Rawls 1971)), Sen recommends a focus on *functionings* and *capabilities* in normative analyses: "The valued functionings may vary from such elementary ones as being adequately nourished and being free from avoidable disease, to very complex activities or personal states, such as being able to take part in the life of the community and having self-respect" (Sen, 1997a, p. 199). Nussbaum and Finnis adopt similar approaches, the former specifying an objective list of universal "capabilities" essential for human flourishing (Nussbaum 2000), the latter "the basic forms of good for us" (Finnis 1980, p. 87-97). Drawing on the same tradition, Culyer advocates an emphasis on health per se as a "characteristic" of persons (Culyer 1989). Under "non-welfarism" then, social concern may encompass utility maximisation 2(c), and/or health maximisation 2(b), plus a range of other objectives 2(d), all of which can be combined in various ways (e).

There is no direct nexus between these welfarist and non-welfarist theories of self-motivation and social goals, and the procedures that are deemed appropriate for a government. At one extreme, the libertarian view 3(c) is that government intervention should be limited to the enforcement of property rights, and protection against force, theft, fraud, and so on (Nozick 1975; Locke 1989). By contrast, paternalists 3(a) advocate coercive measures, such as compulsory taxation and market regulation, to achieve social objectives. Between these extreme views, the archetypal liberal may want government intervention limited to the provision of information and the correction of market failures 3(b), as these are prerequisites to the maximisation of effective choice.

It can be seen from Table 1, under "Combinations", that different forms of welfarism and non-welfarism are possible. For the purposes of the empirical study reported below, the differences under "self-motivation" and "role of government" are irrelevant. Even confining attention to "social goal", however, several forms of non-welfarism are possible. In the remainder of the paper we concentrate on that form of non-welfarism which has received the most attention in the health economics literature, namely "health maximising non-welfarism" (Hurley 2000, p. 65). This form of non-welfarism postulates health per se as an alternative objective to utility in economic evaluations (Culyer 1989; Culyer 1990; Wagstaff 1991), and advocates maximisation as the ranking criterion. This form of non-welfarism "replaces utility with health as the primary outcome of interest for evaluation" (Hurley 1998, p. 375) – at least in the health sector. The empirical

study reported below seeks to compare community support for welfarism and this form of non-welfarism.

3. The Questionnaire and Survey

The survey sought to test the public's support for that version of welfarism identified by WTP and that version of extra-welfarism in which the social objective of a national health scheme is health per se. Prima facie, these two principles embody different levels of abstraction. This asymmetry is a direct result of the two candidate social welfare functions. We return to this issue in the discussion of results.

A question on WTP versus QALYs was headed: **How should we decide which services to include in Medicare?** (Medicare is Australia's universal health insurance scheme.) Respondents were not asked to choose between services directly, but to indicate which of two principles should, in their view, be adopted by decision-makers. More specifically, they were told that "government advisors have two ways for comparing the importance of health services." Descriptions of these were then given, which were intended to explain the alternative benefit-measures used in Cost-Benefit Analysis (CBA) and Cost-Effectiveness Analysis (CEA), namely, WTP and QALY measurement respectively. The purpose was to elicit people's "meta-preferences" for which of these alternative methods should be used; that is, respondents were asked whether they believe decision-makers should respect public preferences (welfarism), or maximise health (health maximising non-welfarism).

We sought to explain WTP and QALYs in such a way that their respective value bases would be easily understood by lay-persons. (Full descriptions are provided in the Appendix.) Because it is difficult to describe WTP in a way that does not introduce unwanted biases – in particular, by focusing attention on issues other than the measure of health outcomes - we designed three version of the questionnaire, each with a somewhat different wording. Differences across sub-sample descriptions are italicised below:

> "The importance of health services should be decided by how much people would be willing to pay for them, if Medicare did not pay for them.
>
> "This method is based on the view that priorities in Medicare should reflect individuals' preferences. The way to measure preferences is to ask individuals how much they would be prepared to pay for each health service. *Hence, the higher their willingness to pay for a service, the higher priority it should have."*

The second version emphasised that WTP is associated with income. To the extent that willingness to pay is conditioned by ability to pay, WTP will favour the wealthy over the poor, and this was expected to reduce support for WTP. The last sentence in the second version read:

> *"The more strongly they feel about a service, and the higher their income, the higher their willingness to pay will be, and hence, the higher the priority the service should have."*

The third version, by contrast, was expected to provide relatively more support for WTP because it focused on "people's opinions" and the value of consulting "members of the community". The explanatory text was:

> *"This method is based on the view that priorities in Medicare should reflect people's opinions. The way to measure their opinions is to ask members of the community how much taxation they would be prepared to pay for each type of health service. Hence, the higher their willingness to pay, the higher priority a service should have."*

The support for each of these versions was then compared with support for the health-maximising alternative which was described identically in all sub-samples:

> "The importance of health services should be decided by how much they improve people's health. This method is based on the view that the role of Medicare is to improve people's health as much as possible. Health would be measured as a combination of the quality and length of life. Hence, the more a service improves the quality and length of lives, the higher priority it should have."

The aim of these questions was to test the main hypothesis that people have a "meta-preference" for the decision rules implied by orthodox welfarism – namely, respecting people's preferences as revealed by their willingness to pay. Additionally, the different emphases in the three versions permitted a weak test of the hypotheses that (i) the association between WTP and personal income would reduce support for the welfarist methodology and, conversely, (ii) that the association of WTP with community action would increase its acceptability.

4. Results

Postal questionnaires were mailed to 3,678 members of the general public in the state of Victoria in Australia. Three similar-sized sub-samples received one of three versions of the questionnaire, which included other questions on priority setting not reported here. The response rate to the survey was 27% (n = 981). Respondent characteristics suggest that our sample was fairly representative of the Victorian adult population, although there were relatively more men (55.3%), and relatively fewer full-time workers (44.5%). The mean age was 51.5 years. See Table 2.

Table 3 shows significantly greater support for allocating resources on the basis of health outcomes (77.4 per cent) compared with the WTP (11.6 per cent). A Chi-square test of the distribution of respondents across the three samples gave no support for the hypothesis that relative support would differ across survey versions ($p = 0.788$).

The results support non-welfarism: people do not want priorities in the government health scheme to be determined by how much people would be willing to pay for them. Rather, there is a "meta-preference" for the criterion of health maximisation. The results also confirm that the criteria of welfarism and health maximising non-welfarism may lead to different conclusions. Surprisingly, the alternative framings of the WTP description in the different versions of the questionnaire had little impact on its level of support. The third version was expected to attract more support because of its focus on people's preferences and the implied participation of the community. The negative connotations associated with the word 'taxation' may have offset the attractiveness of this version.

Table 2: Respondent Characteristics

Characteristic	**Category**	**Years**	**%**
Gender	Male		55.3 (%)
	Female		44.7 (%)
Age	Mean	51.47	
	Standard deviation	15.4	
	Median	50.00	
Children	0		68.5 (%)
	1		12.3 (%)
	2		12.6 (%)
	3		5.3 (%)
	4 +		1.2 (%)
Family size	1		17.1 (%)
	2		38.2 (%)
	3		15.8 (%)
	4		16.8 (%)
	5		9.0 (%)
	6 +		3.1 (%)
Education	No school		6.5 (%)
	Attended high school		16.2 (%)
	Finished high school		20.8 (%)
	Trade qualification		22.7 (%)
	Degree		24.9 (%)
	Postgraduate qualification		4.8 (%)
	Other		10.6 (%)
Main activity	Full-time work		44.5 (%)
	Part-time casual work		14.4 (%)
	Unemployed		2.0 (%)
	Retired or pension		30.5 (%)
	Home duties		8.0 (%)
	Studying		0.7 (%)
Income (Aus $)	< 15,000		18.7 (%)
	15,000 – 30,000		25.7 (%)
	30,000 – 45,000		19.4 (%)
	45,000 – 60,000		16.8 (%)
	> 60,000		19.5 (%)
Self-rated health	Very good		31.8 (%)
	Good		47.6 (%)
	Neither good nor bad		16.3 (%)
	Bad		3.9 (%)
	Very bad		0.4 (%)

Table 3: Percentage of Respondents Opting for WTP or QALYs by Survey Version

	Standard % (*N*)	**Income Emphasis % (*N*)**	**People's Preference Emphasis % (*N*)**	**Total**
WTP	12.9 (41)	11.1 (36)	10.8 (34)	11.6 (111)
QALYs	76.8 (245)	78.5 (255)	76.9 (243)	77.4 (743)
Not sure or other	10.3 (33)	10.4 (34)	12.3 (39)	11.1 (106)
Total	100 (319)	100 (325)	100 (316)	100 (960)

5. Discussion

The notion that various combinations of personal and social motivations may exist is not new. Evans, for example, identifies three different types of "externalities" that might underlie society's interest in an individual's health care: the selfish, the altruistic, and the paternalistic. He notes: "I may well prefer complete discretion over my own care, but feel paternalistic about yours, and vice-versa" (Evans 1984, p. 60). A person might subscribe to complete sovereignty over their own care and, for example, be indifferent about whether a utility gain is the result of a health- or a non-health enhancing attribute, provided the utility gain is the same. At the same time, however, they may subscribe to paternalism for others, and be willing to cross-subsidise only specific types of commodities and sources of satisfaction. This seems to be what our survey detected. The criterion for prioritising health care is not the satisfaction of preferences but the maximisation of health, at least in the case of a publicly funded health scheme.

As noted earlier, it might be objected that the questionnaire does not compare "like with like". Health per se is a relatively concrete concept and, at least in the case of physical health, is directly observable. Benefits identified by a person's WTP are less concrete. Individuals may select services that are not health maximising, but which, in part, satisfy other preferences (for example, for the avoidance of regret or uncertainty (Loomes 1988; Smith 1996; Wu 1999)). It might be objected that our survey results could have been driven by this asymmetry. As noted earlier, the distinction on which this objection is based is a reflection of the nature of the two principles and not an artefact of the questionnaire. The benefit of good health is a relatively simple and direct concept. The benefits arising from people selecting an unknown combination of health services is a more abstract concept. However, it is no more or less abstract than the benefits that are obtained from the principle of consumer sovereignty elsewhere in the economy, which is clearly a widely supported principle, and not so abstract that we should doubt people's capacity to comprehend it. The results of the survey are more consistent with the view that people can and do distinguish between the context of a national health scheme and this broader context. In the latter, services are financed by tax payers who may well doubt the sagacity of their fellow citizens (as they see it) and seek to direct the income they have foregone as taxes to a purpose of their choice. If this were not so there would be widespread support for the replacement of national health services with a system of cash transfers and full consumer sovereignty.

The three different framings of the WTP option gave no significant differences. There was no support for our hypothesis that the association between WTP and personal income would reduce support for the welfarist methodology, nor for the hypothesis that the association of WTP with community action would increase its acceptability. This may be explained by a more general limited cognitive capacity in respondents who are faced with hypothetical scenarios. There is plenty of evidence that individuals in such a choice context employ computational shortcuts, or cognitive strategies, that operate to simplify the decision task (Kahneman, Slovic et al. 1982; Irwin, Slovic et al. 1993; Payne, Bettman et al. 1993; Slovic 1995). For example, several researchers have argued that individuals use "fast and frugal heuristics" when answering preference elicitation questions, which avoid the calculation of probabilities or utilities and limit the search for information (Gigerenzer and Goldstein 1996; Connolly 1999; Gigerenzer, Todd et al. 1999; Dhami and Ayton 2001; Gigerenzer and Selten 2001; Martignon and Hoffrage 2002). In our questionnaire, the text explaining the three different versions of WTP was part of a longer explanatory text below each heading, and it is possible that respondents – to simplify their task - concentrated on the headings rather than the explanations. This may have contributed to the observed similarity in responses to the three different framings of the WTP option.

An additional, potentially confounding, factor was that the headings themselves were (unavoidably) not completely "neutral". The heading for the WTP option was: "The importance of health services should be decided by how much people would be willing to pay for them, if Medicare did not pay for them." This heading might be read as provocative, and inclined to prompt the response, "*Of course* Medicare should pay for them," or possibly, "For private health care, it is acceptable that people's willingness to pay should matter, but not in *Medicare*." Advocates might argue that WTP is a *contingent* valuation exercise, and therefore that the heading should have emphasized respecting people's preferences and valuations, and that WTP is used simply as a yardstick for measuring intensity of preferences. Admittedly, the chosen framing of the WTP option may have given negative connotations. However, we would certainly appreciate more research using alternative descriptions of this welfarist option in order to verify the extent to which there is an inherent "framing bias" in this particular study.

Despite these caveats, which must always be made in the context of a limited-capacity postal survey, we believe that the results are probably best explained at face value. Australians believe that the purpose of their public health service is to address ill health and not maximise individual utility. Australia's national health scheme has been the subject of ongoing debate (over funding and patient co-payments), and it is likely that most Australians have formed a view of the purpose of the scheme. This provides a simple explanation for why no version of the WTP questions was preferred: respondents had a clear perception of the purpose of Medicare and it was not the satisfaction of preferences.

Although the subjects in our survey rejected WTP in favour of health per se, the implications of this are not straightforward. Arguably, the benefits of WTP outweigh community objection to the technique. Three arguments that might be put in support of this are considered below.

5.1 The Appeal to Authority

First, it might be argued that WTP is the "theoretically correct" or "conceptually appropriate" method for valuing health effects (Pauly 1995; Johannesson 1996) and Mishan's well known dictum may be cited that it is better to measure the theoretically correct concept imperfectly - namely, individual preferences - than the wrong concept - namely, health (Mishan 1971, p. 695). However, this is not so much an argument, as an expression of confidence in the general applicability of CBA. CBA and the use of WTP as an index of utility is based upon the theory of (new) "welfare economics" that evolved after Robbins's seminal work (Robbins 1938), and was subsequently described in the classic works of Little (Little 1965) and Graaf (Graaf 1967). Any theory embedded in the theoretical framework of welfare economics draws the (not inconsiderable) support of this tradition. However, this appeal to welfare theory results in a circularity in the argument. As innumerable authors have pointed out, the market for health care has a number of unique characteristics that cast doubt upon the validity of the assumptions of welfare theory (for example (Evans 1984; Rice 1998; Dolan and Olsen 2002)). The most important of these assumptions for the present context is that social welfare is a function only of people's utilities, and the purpose of this study was to determine whether this assumption is supported. It cannot therefore be argued that the results of the study must be rejected because they conflict with theory: the study was designed to test this theory.

5.2 The Scope of WTP

It might also be argued that WTP is the most flexible technique for evaluating health services, as it is able to include a variety of factors in addition to health that are important to individuals, such as reassurance and hope, and the avoidance of regret and uncertainty – in short, that "[t]he advantage of WTP over QALYs stems from the fact that the latter permits the value of health gains only" (Donaldson, Farrar et al. 1997). However, it is unclear at present whether the myriad of non-health factors that can potentially be valued using WTP *should* be included in economic evaluations. Welfarism provides an unambiguous answer to this question: anything that affects an individual's preferences is relevant to the measurement of "utility" and therefore should be included. However, whether the beneficiaries of national health schemes want those schemes to incorporate, for example, "ex ante" sources of utility such as reassurance and hope, or the avoidance of regret and uncertainty, has not been adequately explored.

On the other hand, there is no reason in principle why the QALY approach cannot be extended to include such factors if this accords with community expectations (Richardson, Hall et al. 1996; Smith 1996; Menzel, Gold et al. 1999). Rather than being a pragmatic, second-best device for avoiding the measurement problems of CBA, the QALY approach may come closer to the measurement of social values than WTP, and indeed this is what our survey suggests. If this is true, then the precept articulated by Mishan cited above lends support to the (imperfect) measurement of QALYs rather than the measurement of the wrong concept, which is now WTP.

5.3 The Question of Allocative Efficiency

It might be argued that to achieve allocative efficiency a dollar value must be placed on life, and quality of life, and that WTP (but not QALYs) does this explicitly (Donaldson, Mapp et al. 1996; Drummond 1997). In the absence of such an explicit valuation of life, there is no mechanism for achieving efficiency between the health and other sectors.

However, the fact that benefits are measured in dollars is not an argument for WTP if the dollars relate to the wrong concept. In a national health scheme the tax dollars paid by individuals finance the benefits that others will obtain and there is no compelling nexus between what a person will pay for themself and what they will pay for others (Richardson and Smith 2005). It is for this reason that many have argued that the focus of WTP in this context should shift to social willingness to pay (O'Brien and Gafni 1996; Olsen 1997; Olsen and Donaldson 1998; Pandey and Nathwani 2003). The question then becomes how much each individual is willing to pay for other's health services, with the caveat that the individual will be eligible to receive the services also. One way to achieve impartiality in answering this question is to place the individual behind a "veil of ignorance" (Rawls 1971).

The personal WTP for a service is likely to diverge from the social WTP; that is, from the amount the individual, acting as a citizen, would be prepared to pay, through taxation, for the addition of a service to the national health scheme. The entirely self-interested individual would be prepared to pay a maximum amount based upon their subjective estimate of the likelihood of using the service and the dollar estimate of the benefits they would receive. Acting as a citizen, the individual is likely to adopt a criterion that is different in kind. (Evans and Law 1995, p. 79).

While the social WTP succeeds in breaking the nexus between individual WTP and individual benefits, this property alone does not imply that social WTP is the correct or best way to address the need to monetise benefits. This problem is outside the scope of the present article which is

limited to a comparison of individual WTP and health outcome as maximands in the social welfare function.

6. Conclusion

Our paper set out to achieve two objectives. First, to demonstrate that under the headings of "welfarism" and "non-welfarism" there are, in fact, a plethora of normative theories and a variety of plausible responses from government. It is likely that the appeal of the different theories is context-specific: welfarism is undoubtedly appropriate in some contexts; various forms of non-welfarism might describe public meta-preferences in others. At present, the relevance of contextual factors, and the relationship between different theories and social preferences in the health sector, is not well understood. A detailed map of the ethical terrain relevant to the health sector has not yet been chartered.

Secondly, the empirical section of our paper sought to obtain Australian evidence relevant to the welfarist/non-welfarist controversy. We have argued that it is possible and appropriate to obtain this evidence with simple and direct questions. It is, of course, possible to argue that respondents were misled by the framing of the questions or that they did not understand the implications of their answers. In particular, when answering preference elicitation questions, subjects often employ simplifying heuristics that (inter alia) limit the search for information. Clearly, such heuristic devices can potentially compromise the validity of an elicitation task by encouraging the neglect of relevant information. However, we believe that in the absence of counter evidence it should be assumed that people can understand and respond to straightforward questions.

Contrary to our expectation, their answers did not vary with the framing of the questions and it is possible that this reflects a very clear understanding of the underlying issues. In the last decade the longest running and most discussed social issue in Australia has been the role of private health insurance and the right of individuals to purchase priority care verus the alternative view that access to health services should only be needs-based. The debate reflects the alternative bases for allocating resources discussed here - viz, WTP and health-based criteria.

Subject to the caveats mentioned above, the findings of our study indicate that Australians reject the universal application of welfarist principles. Of course, this does not demonstrate the extent to which welfarism is rejected either in the health sector or elsewhere. Nor does it establish the superiority of health maximising non-welfarism in all health-related contexts. The more cautious conclusion is that welfarism is sometimes rejected, but that its rejection may be context-specific. Further, the rejection of welfarism may be partial, and the optimal policy may well involve a trade-off between different ethical principles. This implies an important future role for the investigation of people's "meta-preferences" for different ethical principles, and the development of techniques for doing this - tasks that have so far received relatively little attention in the literature.

Many would probably find our results unsurprising. It appears more than reasonable that the purpose of a public health service is to maximise health rather than to finance services selected on the basis of people's preferences. Of course, the two criteria would result in two largely overlapping sets of services. But it is desirable to recognise the preferred criterion in order to evaluate services which may not be cost-effective using both criteria of effectiveness.

Appendix

How should we decide which services to include in Medicare?

One of the biggest problems for Medicare is to decide which services to include when there is not enough money to finance all of them. To help solve this problem, government advisers have two ways for comparing the importance of health services.

QUESTION 3: Which of the two methods below do you think should be used to prioritise health services?

*Please tick **one** of the boxes below:*

● The importance of health services should be decided by how much people would be willing to pay for them, if Medicare did not pay for them. 1 ❒

Version 1: This method is based on the view that priorities in Medicare should reflect individuals' preferences. The way to measure preferences is to ask individuals how much they would be prepared to pay for each health service. Hence, the higher their willingness to pay for a service, the higher priority it should have.

Version 2: This method is based on the view that priorities in Medicare should reflect individuals' preferences. The way to measure preferences is to ask individuals how much they would be prepared to pay for each health service. The more strongly they feel about a service, and the **higher their income**, the higher their willingness to pay will be, and hence, the higher the priority the service should have.

Version 3: This method is based on the view that priorities in Medicare should reflect **people's opinions**. The way to measure their opinions is to ask **members of the community** how much **taxation** they would be prepared to pay for each type of health service. Hence, the higher their willingness to pay, the higher priority a service should have.

● The importance of health services should be decided by how much they improve people's health. 2 ❒

This method is based on the view that the role of Medicare is to improve people's health as much as possible. Health would be measured as a combination of the quality and length of life. Hence, the more a service improves the quality and length of lives, the higher priority it should have.

● Not sure 3 ❒

Please explain if you would like another method to be used:

_____

_____

_____

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