Two Conceptions of Solidarity in Health Care

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Abstract

In this paper, I distinguish two conceptions of solidarity, which I call solidarity as beneficence and solidarity as mutual advantage. I argue that only the latter is capable of providing a complete foundation for national universal health care programs. On the mutual advantage account, the rationale for universal insurance is parallel to the rationale for a labor union's "closed shop" policy. In both cases, mandatory participation is necessary in order to stop individuals free-riding on an ongoing system of mutually advantageous cooperation.

Key Words

Solidarity; health care; mutual advantage; social insurance; welfare state.

Introduction

There has been a renewed interest in the value of solidarity lately. Many philosophers see it as a potential justification for welfare state institutions, particularly those institutions that meet people's health care needs.[1] Historically, the value of solidarity has played a prominent role in arguments for expanding the welfare state, especially in the European context (Bayertz 1999: 21-25; Weale 1990: 477-

[1] Recent work on the role of solidarity in justifying health care provision includes Butler 2012; Callahan 2011; Dawson and Verweij 2012; Prainsack and Buyx 2012; Prainsack and Buyx 2017; Segall 2007; Ter Meulen 2015; and West-Oram 2018b. On solidarity in the welfare state more generally, see Lehtonen and Liukko 2015; Schuyt 1998; and Weale 1990. There is also a vast literature on solidarity as a foundational value in public health. However, this paper concerns solidarity as a justification for access to personal health care services, not as a justification for public health measures.

479). Solidarity's connotations of interdependence, collective responsibility, and mutual care and concern make it seem like an appealing basis for national universal health care provision. And for some, solidarity seems like an attractive alternative to the value of equality, in light of the latter value's evident failure to put universal health care provision on a firm foundation (Ter Meulen 2015: 2-3).[2]

There is considerable disagreement among scholars, however, both about the precise meaning of solidarity and about its concrete moral requirements. Adopting John Rawls's distinction between a concept and a conception, we might say that agreement around the meaning of the *concept* of solidarity masks considerable differences among its more particular *conceptions* (Rawls 1999: 5). I agree with Angus Dawson and Marcel Verweij that, at its core, the concept of solidarity involves something like "standing together;" that is, solidarity essentially involves some public display of unity and mutual support (Dawson and Verweij 2012: 1; cf. Kolers 2012 367-368). But a variety of more particular conceptions of solidarity are possible, each of which develops this core concept in different ways. In this paper, I distinguish three such conceptions, but I focus on the first two. I call these three conceptions solidarity as beneficence, solidarity as mutual advantage, and solidarity as forgoing unequal advantages.

Where recent solidarity-based theories of justice in health care mark the distinction among these different conceptions at all, they tend to come down in favor of an understanding of solidarity as beneficence, according to which solidarity involves sacrificing to assist fellow group members or otherwise similar individuals in need.[3] Not only is such a conception seen as more attractive in its own right, compared to the alternatives, but it is also seen as the only conception capable of justifying universal, comprehensive health care provision, since such provision apparently involves the unselfish

[2] For discussion of some of the problems facing egalitarian theories of justice in health care, see Horne 2016; Segall 2010: ch. 2 and 3; Segall 2018; and Sreenivasan 2007.

[3] Partisans of solidarity as beneficence in the health care space include Dawson and Verweij 2012; Prainsack and Buyx 2012; Prainsack and Buyx 2017; Ter Meulen 2015; and West-Oram 2018b. For a defense of my classification of Prainsack, Buyx, and West-Oram's views as versions of solidarity as beneficence, see n. 14 below.

helping of others (Dawson and Verweij 2012: 2; Prainsack and Buyx 2012: 346; Ter Meulen 2015: 4-6). My aim in this paper is to argue that, despite these appearances, solidarity as beneficence cannot provide a solid normative foundation for national universal health care provision. Instead, universal health care is best justified by solidarity understood as mutual advantage.

According to solidarity as mutual advantage as I understand it, the essence of solidarity lies in doing one's part in group-based collective action that benefits everyone, notwithstanding the temptation to free-ride on the contributions of others. The defense of universal health care provision following on this conception of solidarity begins from the idea that sharing responsibility for one another's health care needs can *itself* be seen as a form of collective action for mutual advantage, though one that is also vulnerable to being undermined by certain kinds of free-riding behavior. Sharing responsibility for health care needs involves the pooling of health risks, a form of cooperation that reduces individuals' exposure to uncertainty and thereby raises their welfare; in a word, sharing responsibility for health care needs provides individuals with a valuable kind of *insurance*. At the same time, however, health care insurance schemes are particularly vulnerable to being undermined by adverse selection, a form of free-riding that has the potential to undermine and destroy the source of collective benefit – hence the need for solidarity to sustain cooperation. As I will show, this account of the normative logic of universal health care provision has many features in common with familiar forms of labor solidarity, which also require that individuals "stand together" and refrain from free-riding in order to sustain forms of group-based cooperation for mutual advantage.

The argument of this paper proceeds in three sections. In Section I, I distinguish three conceptions of solidarity, though the rest of the paper focuses on the first two. Against those who would argue that solidarity as mutual advantage is no moral value at all but mere enlightened self-interest, I show that, due to the free-rider problem, solidarity as mutual advantage requires real constraints on individuals' pursuit of their own advantage, and in that sense it represents a genuine moral value. In

section II, I sketch in broad strokes the account of national health care provision that each conception of solidarity puts forward, focusing on that coming from solidarity as mutual advantage. While other theorists have suggested that solidaristic health care systems may be mutually advantageous, my account goes further by spelling out not only the precise mechanism by which sharing responsibility for health care generates collective benefit, but also the specific threat posed to the system by free-riding such that solidarity is called for in order to sustain cooperation. Finally, in Section III, I assess the merits of the two accounts, arguing that solidarity as mutual advantage offers a better defense of national universal health care systems compared to solidarity as beneficence. It seems to me that theorists of solidarity have not done the work that egalitarians, for example, have done when it comes to spelling out the implications of their view for the precise shape and scope of health care institutions; section III represents a step in that direction.

I would emphasize here at the outset that this paper concerns solidarity as a value, one that can potentially provide a normative justification for certain welfare state institutions. Solidarity can also be used in a descriptive sense, either at an individual level (referring to individuals' attitudes or feelings towards similar others or their disposition to help others) or at a social level (referring to social cohesion, the extent to which a group in fact hangs together).[4] I will have occasion to refer to solidarity in these descriptive senses, but I do not mean to offer a theory of solidarity as a psychological or sociological phenomenon. I am interested in the *value* of solidarity and the kinds of political obligations it generates.

[4] For discussion, see Bayertz 1999.

I. Two (or Three) Conceptions of Solidarity Distinguished

Solidarity is a notoriously difficult concept to analyze. As I have said, the core of the concept seems to involve "standing together" – that is, acts of solidarity seem to be public acts expressing identification with others as well as mutual commitment and support. Beyond that, however, things get complicated. Solidarity has been said to involve such diverse elements as mutual care and concern; shared aims or goals; a sense of interdependence, collective responsibility, or shared fate; reciprocity; a willingness to carry costs or make sacrifices; and probably a great many other things as well.[5] This conceptual complexity is amplified by the incredible diversity of groups and organizations that can be said to exhibit solidarity. These range from a small group of known workers in a union shop to a tight-knit ethnic or religious community to a modern, diverse nation-state – and even, according to some scholars, to humanity as a whole (Ter Meulen 2015: 5; West-Oram and Buyx 2017).

I think we can make some progress by sorting conceptions of solidarity according to the kinds of reasons for action or reasons for policy that they take reasons of solidarity to be. In particular, does the value of solidarity speak in favor of aiding relevantly similar individuals, or does it speak instead in favor of doing one's part in collective action? Or does solidarity perhaps speak in favor of forgoing advantages that are not equally available to other group members? These represent distinct reasons for action or policy, and they have distinct implications for the shape and scope of health care institutions. Seeing this can help us not only attain some analytic clarity, but also to assess which conception of solidarity will put universal health care programs on their firmest foundation. To be clear, it is not my intention here to argue that only one of these conceptions amounts to "true solidarity," or "solidarity properly understood;" it seems to me that only someone in the grips of a theory could deny that there are clear

[5] For analyses of the concept of solidarity, in addition to the works related to health care listed in n.1 above, see Jennings and Dawson 2015; Dean 1995; Eckenwiller, Straehle, and Chung 2012; Heyd 2007; Kolers 2016; Mason 2000; Rehg 2007; Shelby 2002; Taylor 2015; West-Oram 2018a;West-Oram and Buyx 2017; and Young 2000.

instances of solidarity that fit each of these conceptions. Rather, my strategy will be to work out the implications of each of these conceptions for the shape and scope of health care institutions, and to argue that only one of these conceptions can adequately justify a national universal health care system.

The conception of solidarity that has received the most attention in the recent literature on health care provision is the one that I call solidarity as beneficence. This view locates the essence of solidarity in the helping of a relevantly similar individual in need. Barbara Prainsack and Alena Buyx understand solidarity as an "enacted commitment to carry 'costs' (financial, social, emotional, or otherwise) to assist others with whom a person or persons recognize similarity in a relevant respect" (2012: 346). Ruud Ter Meulen argues that solidarity involves "the unselfish dedication to a fellow human being who is in need" (2015: 4). On this conception, reasons of solidarity are quasi-altruistic reasons to help others – the difference between altruism and solidarity being perhaps only that reasons of altruism are reasons to help *all* others, while reasons of solidarity are more partial and directed towards those with whom one recognizes some similarity (Prainsack and Buyx 2012: 348). But of course, the required similarity can be arbitrarily thin – Ter Meulen even speaks of "humanitarian solidarity," which involves (he says) a willingness to take responsibility for the well-being of other human beings as such (2015: 5).

In its most general form, solidarity as beneficence sees solidarity as a matter of "standing up *for*" similar others – standing up for them in the sense of helping them and protecting them from harm (Jennings and Dawson 2015: 36). What solidarity as beneficence requires more specifically varies from theorist to theorist; some speak as though solidarity demands merely that we benefit others *somewhat* (Prainsack and Buyx 2012: 346), while others speak about solidarity's demands in more precise terms – e.g. as being broadly sufficientarian (Schuyt 1998: 298; Ter Meulen 2015: 5), prioritarian (Butler 2012: 355-356; Rawls 1999: 90-91), or egalitarian (Weale 1990: 478). While I think that there are obvious reasons to prefer a more specific account of what solidarity requires, the discussion that follows will remain neutral among these different ways of specifying the demands of solidarity as beneficence.

Distinct from solidarity as beneficence is a second conception of solidarity, which I call "solidarity as mutual advantage." This conception applies in the context of a group of people who "stand together" in pursuit of a shared interest or common goal.[6] Those who share an interest will often find that they can advance that interest more effectively through collective action. Yet while collective action can be mutually advantageous, we cannot always count on prudence or self-interest alone to give individuals sufficient reason to do their part; this is because various forms of free-riding will often prove to be more individually advantageous. Here the value of solidarity enters, calling on each group member to refrain from free-riding and do her part in the cooperative scheme. Reasons of solidarity on this conception are reasons that group members have to do their part in mutually advantageous group-based collective action.[7]

The most familiar examples of solidarity as mutual advantage come from the labor movement. Labor unions are advantageous to workers principally because the workers united have much greater bargaining power than any worker has on her own; this in turn is because the threat of all workers walking off the job is a much more serious threat to the employer than the threat of any one person quitting or refusing to work. At the same time, although the greater bargaining power of the union may be advantageous to workers as a group, the temptation for any individual worker to free ride on the

[6] There is surprisingly little written in the health care space from the point of view of solidarity as mutual advantage in this sense. West-Oram 2018b has elements of a mutual advantage view, but I think he ultimately falls on the side of solidarity as beneficence; see the discussion in §II below and in n.14. Some theorists of solidarity in health *recognize* the existence of a form of solidarity that operates according to the logic of mutual advantage, but downplay its moral value or its applicability to health care; see e.g. Dawson and Verweij 2012: 2; Ter Meulen 2015: 4-5 and 8-11.

[7] Not all instances of cooperation for mutual advantage count as enacting *solidarity*. For instance, while ordinary market transactions are mutually advantageous, we do not normally speak of solidarity between buyer and seller. As distinct from "mere" cooperation, solidarity as mutual advantage seems to apply in cases where a group of individuals is cooperating to realize a shared goal or goals, as opposed to individuals working together to advance their own discrete goals (as in market transactions). Moreover, solidarity as mutual advantage seems to apply in cases where there is some plausible need to "stand together" in order to achieve the shared goal, perhaps because there is some kind of threshold effect or increasing returns to scale or – in the case of health care insurance – asymmetries of information.

efforts of the rest is normally also quite strong. Crossing a picket line to return to work during a strike, for example, can be quite advantageous to an individual worker, even as doing so can also undermine the bargaining power of the entire group. This is why the value of solidarity is so central to the labor movement: union members must "stand together" and refrain from free-riding in order to sustain the benefits of collective action.

Partisans of solidarity as beneficence sometimes diminish solidarity as mutual advantage by associating it with mere self-interestedness (Ter Meulen 2015: 3-4). For example, it might seem that the problem with strike-breaking is that, while in the short run it may provide the worker with needed income, in the long run it will cause the strike action to fail, leaving the worker herself worse off. The call to solidarity is thus seen as nothing more than a call to attend to one's own long-term advantage.

It is important to see that this reduction of solidarity as mutual advantage to enlightened prudence is simply mistaken. It rests on a straightforward fallacy of division: just because *everyone* is better off when *everyone* cooperates, it does not follow that *each one* does best when *each one* cooperates. Notice that, except perhaps in very rare cases, no one person's contribution will be decisive for the success or failure of a strike action; the outcome vis-à-vis the employer will normally be the same regardless of what any one individual worker does. This means that whenever an individual worker considers the matter solely from the point of view of her own self-interest, she must conclude that the decision to walk the picket line is in some sense an act of pure self-sacrifice. Importantly, nothing about this calculation changes just because, if all workers reason thusly, the strike will surely fail; indeed, it is no more in an individual's self-interest to sacrifice for the sake of a failed strike than it is to sacrifice for the sake of a successful one. All of this is just to say that the situation has the structure of a prisoner's dilemma, where individual defection really is each player's dominant strategy, notwithstanding the fact that mutual defection is Pareto-inferior to mutual cooperation. In this sense, solidarity as mutual

advantage requires the acceptance of real constraints on the pursuit of individual self-interest, and therefore it represents a genuine *moral* value.[8]

While solidarity as mutual advantage represents a real moral value, its normative logic is nonetheless quite distinct from that of solidarity as beneficence. Solidarity as beneficence sees solidarity as something akin to an act of charity, albeit charity directed towards relevantly similar individuals. By contrast, solidarity as mutual advantage sees solidarity as a matter of doing one's part in collective action toward shared goals. This latter notion is obviously more fitting in the context of the labor movement, as unions are not in the first instance benevolent societies. Whatever solidaristic reasons a union member has to participate in the strike are simply distorted if they are expressed in terms of a quasi-altruistic obligation to assist other group members in need. Rather, the union member's reasons are better understood as reasons to do her part in *the strike*, understood as a form of irreducibly collective action. In this respect, at least, solidarity as mutual advantage happens to be a less individualistic conception of solidarity compared to solidarity as beneficence. We might say that solidarity as mutual advantage sees solidarity as a matter of "standing up *with*," rather than *for*, similar others.[9]

Of course, as with solidarity as beneficence, the specific demands of solidarity as mutual advantage are quite vague and need further specification. What it means to do one's part in cooperation, and to benefit appropriately, needs to be spelled out. For now, I would simply note that there is nothing in the nature of solidarity as mutual advantage that rules out a concern for fairness or

[8] Incidentally, this is why the attempt to show how solidarity can arise from self-interest in West-Oram 2018a and West-Oram 2018b must fail: because of the free-rider problem. It simply does not follow from the fact that something is in the interest of *the group* that it will therefore be in the interest of *each member of the group*; free-riding strategies will typically be more individually advantageous. Thus acting in solidarity always already involves some constraint on the pursuit of self-interest.

[9] The phrase "Standing up with" is from Jennings and Dawson 2015: 36-7. However, I use the term slightly differently than they do. Dawson and Jennings see "standing up with" as involving fellowship and mutual recognition, whereas I use it to refer to collective action toward shared goals.

equity in the distribution of the benefits and burdens of collective action. Labor unions, for example, typically take pains to ensure that their poorest and most vulnerable members benefit most from any particular round of bargaining, even as they also try to ensure that everyone – even their most advantaged members – gains somewhat relative to the status quo. The point is that solidarity as mutual advantage need not imply that each individual is concerned to advantage herself maximally, without concern for fairness or equity; indeed, that kind of ruthlessness is inconsistent with solidarity as mutual advantage, since that is precisely what gives rise to the free-rider problem in the first place.

A third conception of solidarity is available, which I mention here only to set aside for the remainder of this essay. This third conception holds that reasons of solidarity are reasons to refuse advantages that are not equally available to other group members or otherwise similar individuals. We might call this "solidarity as forgoing unequal advantages," or more tendentiously, "solidarity as leveling down." This conception holds that solidarity requires refusing privileges that other group members or similar individuals do not enjoy.[10] For example, one might think of cases where a member of a disadvantaged group refuses benefits that she might obtain by "passing" as member of a more privileged group (Silvermint 2018). One might think also of those opposite-sex couples who refused to marry until marriage rights were extended to same-sex couples as well. These are both cases where individuals appear to forgo personal advantages on the grounds that such advantages are not equally available to all relevantly similar others.

[10] It is not clear whether this third conception is always fully distinct from the other two. For example, I might forgo unequal advantages in order to deliver a symbolic or emotional benefit to others; in that case, it seems I have in fact performed an act of beneficence rather than an act of pure leveling down. Similarly, if I forgo unequal advantages as part of a political strategy meant to advance the interests of my group, then my action might better be described as an instance of solidarity as mutual advantage. Thus, although this third conception is distinct in theory, one might wonder how many pure cases of solidarity as forgoing unequal advantages there really are in practice.

I leave this third conception aside for the rest of this paper, however, for the simple reason that such a conception is obviously unfit to serve as a foundational justification for universal health care. Whatever its other merits, one cannot "forgo" or "level down" to a national universal health care system. We need some account of the advantages that should be available to all before we can discuss the question of whether group members ought to forgo unequal advantages beyond that point.[11]

In this section, I have distinguished three conceptions of solidarity according to the kinds of reasons for action or for policy that each takes reasons of solidarity to be. Are reasons of solidarity reasons to assist other individuals in need, or are they reasons to do one's part in group-based cooperation? Or are they perhaps reasons to forgo advantages not equally enjoyed by all? Other theorists have preferred to sort conceptions of solidarity according to the nature of the underlying solidary bond – for example, whether it is a bond of shared identity, history, or culture, or whether it is a bond of shared interests or common predicament.[12] I would point out, however, that this alternative way of mapping the terrain seems to line up quite neatly with my own. If a solidary group is bound primarily by shared interests or a common predicament, it seems natural that the demands of solidarity should operate according to the logic of mutual advantage. To the extent that a solidary group is bound by deeper ties of shared identity, history, or culture, then perhaps a more altruistic concern for the good of one's fellows, or even a willingness to forgo advantages that others may not enjoy, may be appropriate. Indeed, given that solidarity as beneficence and solidarity as forgoing unequal advantages

[11] These considerations suggest that solidarity as forgoing unequal advantages may have a role to play in arguments surrounding the justice of so-called "two-tiered" health care systems, where all citizens have access to a certain basic level of care but better-off citizens are able to purchase additional care beyond that basic level.
[12] Dawson & Verweij 2012, for example, distinguish "rational" and "constitutive" solidarity; Ter Meulen 2015 likewise distinguishes "instrumental" and "intrinsic" solidarity. Looking beyond the space of solidarity in health care, Shelby 2002's distinction between the "common oppression theory" and the "collective self-determination theory" of black political solidarity amounts to a distinction between a conception of solidarity based in shared *interests* versus one grounded in shared *identity*. Something similar can be said of Kolers 2016's distinction between "teleological" and "loyalty" solidarity and of Dean 1995's distinction between "affectional" and "conventional" solidarity.

can require greater sacrifices from individuals compared with solidarity as mutual advantage, it seems reasonable to suppose that they also depend on stronger underlying bonds of group identification and mutual care compared to the latter.[13] The fact that this alternative way of approaching the concept of solidarity yields a similar picture of the available *conceptions* of solidarity would seem to support this way of mapping the conceptual space.

II. Applying the Two Conceptions to Health Care

My principal aim in this paper is to determine which conception of solidarity provides the best normative foundation for universal health care provision. In this section, then, I want to offer a broad sketch of the kind of justification each conception would offer for meeting fellow citizens' health care needs. In the next section, I turn to assessing the merits of the two accounts.

The picture of universal health care provision coming from solidarity as beneficence is straightforward. According to solidarity as beneficence, we have non-instrumental obligations to carry costs in order to assist relevantly similar individuals in need. Since health care is arguably one of our most basic needs, it seems to follow that, as residents of the nation-state, we have obligations to make sure that our fellow residents are able to meet those needs. To that end, we erect national health care or health care insurance systems. As Prainsack & Buyx succinctly put it, one way of enacting solidarity is "by collecting taxes from the population to fund the services provided to those in need of health care"

[13] With this in mind, to the extent that a modern, pluralistic nation-state lacks the bonds of shared national identity, history, and culture necessary to underwrite the more demanding obligations of solidarity as beneficence, that alone would appear to speak in favor of adopting a thinner conception of solidarity as mutual advantage, at least for the purposes of defending the core institutions of the welfare state. But I will not pursue that line of argument further in this paper.

(Prainsack and Buyx 2012: 344).[14] Obviously this account needs to be fleshed out in various ways, but the underlying idea – that solidarity entails a direct reason to help others meet their health care needs – is clear.[15]

The justification coming from solidarity as mutual advantage requires a somewhat lengthier exposition. It is not enough to observe, as Peter West-Oram has, that health care systems where responsibility for health care needs is shared—i.e. "solidaristic" health care systems—tend to have lower costs and better health outcomes compared to more individualistic, market-oriented systems (West-Oram 2018b: 581-582). For one thing, we should demand some account of the actual mechanism by which sharing responsibility for health care needs yields these efficiencies; after all, it may be that European health care systems are more efficient than the American one for cultural or political reasons unrelated to their "solidaristic" character. As well, we should demand some account of the specific threat to these health care systems posed by the temptation to free-ride; otherwise it is not so clear that these so-called "solidaristic" health care systems call for real solidarity at all. (One need not appeal to the value of *solidarity* to justify a preference for a cheaper, more effective option over one that is both shoddier and more expensive -- enlightened prudence alone should suffice!) Thus, a justification for universal health care grounded in solidarity as mutual advantage should be able to identify both the

[14] I classify Prainsack and Buyx's view (along with West-Oram's, insofar as he follows them) as versions of solidarity as beneficence. This may seem tendentious, particularly given that all three affirm at various points that solidaristic practices *can be* mutually beneficial. For the purposes of my classification, however, what matters is that all three consistently hold that solidaristic acts or practices are those that involve carrying costs *to assist others* (beneficence), not carrying costs to *do one's part in collective action* (mutual advantage). Of course, if everyone assists everyone else, then everyone may end up better off than they were before; in other words, widespread beneficence can be mutually advantageous. But for Prainsack and Buyx (and presumably also West-Oram), mutual advantage cannot be the reason why solidary acts or practices are undertaken. The essence of solidarity, on their view, lies in acts of helping done from a recognition of similarity, not in collective action for mutual advantage. Moreover, Prainsack and Buyx explicitly deny what solidarity as mutual advantage asserts, namely, that free-riding behavior represents a failure of solidarity; they see free-riding instead as a failure of *reciprocity*, and they hold that reciprocity is inconsistent with solidarity at the most basic, interpersonal level. For their account of solidarity, see e.g. Prainsack and Buyx 2012: 344-346; West-Oram 2018b: 581-4. On the purported difference between solidarity and reciprocity, see Prainsack and Buyx 2017: 61-62 and 159-160.

[15] For other accounts in the vein of solidarity as beneficence, see the discussion in the first half of §I.

mechanism by which collective action in the health care space produces mutual benefit, as well as the specific *threat* posed by the possibility of free-riding, such that the value of solidarity is called for in order to sustain cooperation.

In fact, there are many distinct ways in which individuals work together for mutual advantage in the space of health care. For an account of justice in health care grounded in solidarity as mutual advantage, the challenge will be to identify a form of cooperation in health care that is sufficiently important, and sufficiently pervasive, that it can plausibly serve as a basis for the justification of the *entire system* (or alternatively, to identify several such mechanisms that could be patched together in the right kind of way). For instance, it has been observed that communicable disease is a kind of "public bad," and limiting its spread offers clear advantages to everyone (West-Oram 2018b). As important as this may be, however, such reasoning cannot by itself provide a justification for the entire health care system. This is simply because the treatment and prevention of communicable disease is such a small fraction of what real-world health care systems do, especially in the developed world.[16] We cannot conclude from the fact that *one part* of the healthcare system is mutually advantageous that therefore the *whole system* can be said to be justified in the name of mutual advantage.

Fortunately, there is a very general mechanism by which individuals "stand together" for mutual advantage when it comes to the provision of health care. Indeed, sharing responsibility for expensive and unpredictable health care needs can *itself* be seen as a form of collective action for mutual advantage. This is because spreading the risk of costly medical needs over a large group of people makes those risks more manageable for individuals, providing them with a valuable kind of security. This

[16] West-Oram appears to make just this mistake in his attempt to provide a solidaristic justification of universal health care. He rests his account on the mutual benefits in treating and preventing infectious disease, seeming not to notice that this provides no justification at all for the rest of the health care system -- which is to say, *most* of the health care system (West-Oram 2018b: 582-583). According to the Kaiser Family Foundation, for instance, spending on infectious disease accounted for less than 4% of total US health care expenditure in 2013 (Cox 2017).

insurance is itself something quite valuable to individuals, at least to the extent that they are risk-averse. But at the same time, as a cooperative strategy, sharing responsibility for health care needs is vulnerable to being undermined by various free-riding strategies, most notably the problem of adverse selection, which I will explain below. This is why the value of solidarity is called for: individuals must stand together and refrain from free-riding in order to prevent the shared-responsibility system from unravelling, thereby preserving a source of collective benefit. The remainder of this section spells out this argument in greater detail.[17]

To see how sharing responsibility for health care needs yields mutual advantage, it may help to start by imagining a world where responsibility for health care was fully individualized. What would it be like to plan for one's own health needs in such a world? The task would be quite daunting, not least of all due to the great unpredictability of health needs. You might know that the expected health care costs of a person of your age and gender will be something like, say, $5,000 over the coming year. But to know this is to know a mere statistical expectation; it tells you very little about what your actual health care costs will be in the year to come. If you are like most people, your actual health care costs in any given year will probably be very little, perhaps next to nothing, notwithstanding your high expected costs. But there is still the small but very real chance of a range of extremely costly outcomes, requiring tens or even hundreds of thousands of dollars in care.[18] If you were to save exactly $5,000 to cover your health needs over the coming year, you would be almost certain to find yourself either seriously over- or under-prepared (Lehtonen and Liukko 2015: 157-158). If you are risk-averse, as many people are, you would gladly trade the highly uncertain gamble that you currently face, with its expected value of a

[17] The following account of insurance and how it works follows Heath 2006a: 322-324. See also Goodin 1988: 157-160; Moss 2002: 22-52; Horne 2017: 574-577.
[18] On the distribution of health care spending in the US population, for example, see NIHCM 2017.

$5,000 loss, for the certainty of a $5,000 loss – in this way, you could better plan for the future and protect yourself against a range of unlikely but potentially disastrous outcomes.

This is not something you can do by yourself, of course, but you can do it by "standing together" with others. This is thanks to the law of large numbers, which says that as you increase the number of trials of a gamble, the average result will tend to converge on the expected value. In other words, increasing the number of trials produces what is known as statistical stability (Hacking 2002: 190-191). The law of large numbers implies that, though it may be practically impossible to predict any particular individual's health care costs with any real accuracy, the average costs of a large-enough group of similarly-situated individuals will be quite predictable indeed. Thus, by pooling your future health care costs with a large-enough group of people – by *sharing responsibility for one another's health care needs* – you can effectively swap your expected health care costs of $5,000 per year for the near-certainty of a $5,000 yearly premium, plus of course the costs associated with administering the program (Lehtonen and Liukko 2015: 157).[19] By spreading the costs of individually unlikely but very expensive outcomes over the whole group, the costs are made both more certain for all and more manageable for those who need care. This arrangement is advantageous looking forward because most people are risk-averse; most people prefer the greater certainty that sharing responsibility provides over the riskier returns associated with going it alone.

The system of shared responsibility for health care needs just described is usually referred to as an insurance scheme. That said, I would emphasize that the same kinds of advantages can be realized by structuring the collective provision of health care in other ways, for example by pooling people's resources to hire physicians and nurses directly to provide care to individuals. This is what goes in in both Beveridge-model systems of socialized medicine like the UK's NHS as well as in private HMO's in

[19] I am assuming here that people's future health costs are at least somewhat independent of one another

the US. Though they look quite different, they all have in common that they involve sharing responsibility and hence sharing risk to make individual's health care expenses more stable and more manageable.

Yet the fact that sharing responsibility for health needs can be mutually advantageous in these ways does not yet show that such sharing calls for true *solidarity*. Again, if an arrangement like health insurance is advantageous to each individual, then prudence alone should give them sufficient reason to participate; the appeal to solidarity would seem superfluous.[20] The role for solidarity becomes apparent only once we see that, besides being mutually advantageous, health care insurance is also vulnerable to being undermined by free-riding. The most significant form of free-riding in health care insurance programs goes by the name of adverse selection (Akerloff 1970; Arrow 1963; Cutler and Zeckhauser 1998). Adverse selection can occur whenever individuals facing relatively higher expected future health care costs are able to hide this fact and obtain insurance at the same price as lower-cost individuals (Heath 2006a: 332). At any given price for voluntary health insurance, we should expect those with relatively higher expected costs to be more inclined to purchase insurance compared to those with relatively lower costs; at any given price, insurance is simply a more attractive deal for higher-cost individuals. The typical result is an insurance pool that includes a preponderance of these high-risk persons; this selection of risks is "adverse" in the sense that it puts an upward pressure on costs and hence on premiums for those in the insurance pool.

In a voluntary market for health insurance, as premiums start to rise, lower-cost individuals will tend to respond by dropping out of the insurance pool altogether. This in turn causes average costs and hence premiums to rise even further. Over time, this dynamic of rising average costs leading to rising

[20] This is where I part ways with Lehtonen and Liukko 2015. While their account of how insurance works and why it is beneficial is correct, it is unclear on their view why *solidarity* is called for in order to sustain it. It is only once we see not only the potential for mutual advantage but also the threat posed by the free-rider problem that we see the need for solidarity as distinct from mere enlightened prudence.

premiums leading to further rising costs can continue to the point that insurance becomes impractically expensive for anyone who is not already seriously ill, and thus the pool effectively prices itself out of existence. This phenomenon, known as the "adverse selection death spiral," results in the loss of a significant source of mutual advantage – everyone is worse off, in virtue of being less protected against the vagaries of chance, due to the general unavailability of insurance.[21] Of course, there are voluntary ways of preventing adverse selection from occurring, through medical underwriting and the like, but these methods have costs of their own. Indeed, one significant source of cost savings in universal, "solidaristic" systems is through the elimination of many of the administrative costs associated with market-based attempts to control adverse selection (see e.g. Woolhandler, Campbell, and Himmelstein 2003).

The value of solidarity enters here, speaking in favor of "standing together" to prevent these free-riders from undermining the system of mutual advantage. Perhaps the most straightforward way of doing this is by not allowing low-cost individuals to leave the insurance pool in the first place, thereby preventing the "death spiral" from getting started. We might imagine the value of solidarity placing an individual moral obligation on individuals to carry insurance even when it is not in their maximal self-interest to do so. More realistically, the value of solidarity might justify a policy of *mandating* that everyone carry insurance, or a policy whereby the state simply provides insurance or health care directly to all. Forcing everyone to "stand together" in these ways effectively preserves an important source of mutual benefit.

I would emphasize here that this rationale for universal, mandatory health insurance is exactly parallel to the rationale for the "closed shop" policy that we see in organized labor. A "closed shop" policy is a policy whereby all workers must belong to the union, or at least pay dues to the union, in

[21] For an account of the death spiral in action, see Cutler and Zeckhauser 1998.

order to work in the shop. In both cases, mandatory participation prevents a very attractive form of free-riding from undermining an important source of mutual benefit. In the union case, it is clearly advantageous to individuals if they can enjoy the benefits of collective bargaining without paying dues or providing other costly forms of support to the union – i.e. if they can free-ride on the contributions of others. However, it is equally clear that, if such behavior becomes sufficiently widespread, the union as a whole will fail, and all workers will end up worse off because of it. Similarly, in the health insurance case, there are obvious benefits to individuals in waiting to purchase insurance until they become sick, counting on the contributions of others to keep the insurance scheme going right up until the point that they come to need its protection. But just as in the union case, if everyone does this, then the whole scheme will fail – the insurance pool will slip into a "death spiral" and collapse, leaving everyone worse off. Insofar as individuals want to enjoy the benefits of collective bargaining or protection against health risk, there is good reason for them to want to bind themselves in advance to participation in the scheme, thus guaranteeing its viability going forward. In both cases, the aim is not to make beneficence compulsory, but rather to prevent individuals from succumbing to the temptation to free-ride. Both of these examples, by the way, show quite clearly how *institutionalized* solidarity often relies very little on voluntary, spontaneous acts of cooperation done from a sense of belonging, and instead simply forces people to "stand together" whether they feel like it or not (cf. Prainsack and Buyx 2012: 346-348).

To sum up the argument of this section: the two conceptions of solidarity distinguished in this paper offer two quite different accounts of the normative logic of universal health care systems. Solidarity as beneficence holds that the essence of the health care system lies in the care and assistance that the healthy provide to the sick *ex post*, so to speak. Knowing who is healthy and who is sick, solidarity as beneficence asserts simply and intuitively that the former have an obligation in solidarity to "stand up for" and assist the latter. From the point of view of solidarity as mutual advantage, by contrast, that story is, in a sense, exactly backwards – it is mistaking effect for cause (Heath 2006b: 130-

131). For solidarity as mutual advantage, the normative core of the health care system is seen in the mutually advantageous commitment *ex ante* to care for the sick, whomever they turn out to be. Sharing responsibility for health needs is a matter of "standing up *with*" one another, providing everyone with the stability and peace of mind that comes from being able to plan for their health care needs more effectively. On the account coming from solidarity as mutual advantage, national health care programs must be universal, not so that no one escapes *care,* but so that no one escapes *contribution*, in order that the system is not undermined by free-riders.

Before closing this section, a brief word is in order regarding how the account of health care provision developed here relates to existing theories of justice in health care coming out of the contractualist tradition. Contractualists such as Rawls propose that we think of society as a system of cooperation for mutual advantage, and furthermore that we should see principles of justice as principles for determining a fair distribution of the benefits and burdens of that cooperation (Rawls 1999: 4). This has obvious similarities to my notion of solidarity as mutual advantage, but there are significant differences between existing Rawlsian accounts of justice in health care and the account developed here. For one, while contractualists like Rawls see society *as a whole* as a system of cooperation for mutual advantage, they have not generally attempted to articulate the specific mechanisms by which particular systems of cooperation actually works to make people better off (with the notable exception of Joseph Heath, whose work I draw on in many ways – see especially Heath 2006a). Instead, contractualists have largely devoted themselves to the task of proposing and defending principles for *distributing* the benefits of social cooperation, regardless of how those benefits may have been produced. Thus, the most prominent Rawlsian account of justice in health care, found in the work of Norman Daniels, locates our duties of justice in health care under a Rawlsian principle of fair equality of opportunity and then works out the implications of that choice (Daniels 2008); the notion that health

care provision might itself be a form of cooperation for mutual advantage plays no role in Daniels's theory.[22]

My account, by contrast, proposes that we should see not *society in general* but rather *the health care system in particular* as a system of cooperation for mutual advantage – and my account describes in some detail how the health care system actually works to produce benefits for everyone. It seems to me that the internal logic of the health care system, and of social insurance more broadly, is best expressed in terms of solidarity rather than equality, involving as it does a group of people "standing together" and "sharing one another's fate" for the sake of mutual advantage.[23] It is true that, insofar as the health care system is mutually advantageous, one might well represent it as the object of a hypothetical agreement among individuals, as contractualists are wont to do; I do not see any deep incompatibility between the account offered here and the broader contractualist framework. But I do wonder whether the idea of a hypothetical agreement best captures the reasons we have to establish a universal health care system, compared to reasons that might fit more naturally with a solidaristic framework, such as our shared group membership or our recognition of a common vulnerability. Of course, having said all of that, the contractualist's question of what constitutes a fair or just distribution of health care's burdens and benefits remains unanswered by my account so far; in the next section, I will say a few words about how a theory of justice in health care based in solidarity as mutual advantage would approach that question.

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[22]. There are well-known problems with existing liberal-egalitarian theories of justice in health care, including Daniels's; see the works cited in n.2 above. Some of the objections I raise against solidarity as beneficence in the next section could also be pressed against egalitarian views.

[23] Even Ronald Dworkin, who is not a contractualist and whose account (like mine) emphasizes the *insurance* aspect of health care provision, wrongly sees insurance as promoting equality rather than mutual advantage. Dworkin appears to reason that, since equality requires the compensation of undeserved disadvantages, and since health insurance compensates people for undeserved disadvantages, therefore equality requires the universal provision of health insurance. As I argued just above, I think this gets the logic of the health care system exactly backwards. Insurance is better understood as a form of cooperation for managing risk and hence for mutual advantage. The equalization of undeserved disadvantage *ex post* is merely a beneficial side-effect. See Dworkin 2000, especially chapters 2 and 8.

III. Assessing the Two Accounts

My primary aim in this paper is to determine which of these two accounts of solidarity in health care puts universal health care provision on the firmest normative foundation. Many recent attempts to justify universal health care provision on solidaristic grounds have come down on the side of some version of solidarity as beneficence.[24] I think this is a mistake. As a justification for a universal health care system, solidarity as beneficence suffers from serious flaws. In this section, I lay out those flaws, showing along the way that these same flaws do not affect solidarity as mutual advantage. I close by briefly defending the account coming from solidarity as mutual advantage against a common objection.

At its core, solidarity as beneficence holds that we have obligations to assist other group members in need, at some cost to ourselves. The view is appealing when stated so abstractly, but there are serious obstacles on the path from that general formula to a defense of a universal health care system. For example, who counts as being "in need" when it comes to health care? It is perhaps tempting to suppose that anyone who has a treatable medical condition should be considered "in need" in the relevant sense, since that would provide a tidy justification for universal health care provision. Unfortunately, this involves an equivocation on the meaning of the phrase "in need." A rich person with a sore throat may need medical care, but she is not *needy* in the sense that typically triggers public altruistic obligations. One might just as well say that a lawyer made to work through lunch is owed public nutritional assistance, or that a financier caught in the rain is owed public housing assistance, just because at that moment the person "needs" food or "needs" shelter. The fact that everyone needs food at one time or another is not an argument for universal nutritional assistance, much less for

[24]For references, see the first part of §I and the works cited there.

nationalizing the food industry; those benefits are properly restricted to those who are truly *needy* overall. It is hard to see why the same point should not be true of health care (Horne 2016).

These considerations suggest that, if solidarity as beneficence is what lies behind public health care provision, then such provision should be conceived as a targeted benefit for the poor rather than as a truly universal program. If our obligations of solidarity are obligations to help fellow group members in need, then plausibly our obligations extend only to those who are truly *needy*.[25] Solidarity as beneficence therefore seems to offer no compelling reason for providing health care to rich or middle-class citizens (although there may be reasons related to political expediency for doing so). Some theorists might regard this as a welcome conclusion, perhaps seeing in means-testing a way of making public programs more progressive. But I suspect that most theorists of solidarity would not welcome this result; presumably, one reason for appealing to solidarity in health care is to defend a truly *universal* system, one where we *all* "stand together."

Solidarity as mutual advantage has a ready answer to the question of why the health care system should cover rich citizens as well as poor ones. The reason is not that rich citizens are group members in need – as, again, they are not. The reason is rather to prevent the rich from availing themselves of a free-riding strategy. To allow the rich to opt out of the universal health care system and seek their own private insurance arrangements is to invite a problem sometimes called "cream-skimming," where the healthiest people – the "best risks," so to speak – are lured away from the universal system by lower prices elsewhere, leaving only high-cost persons behind. This would make the public system itself a victim of an adverse selection problem (Heath 2003). Universal, mandatory

[25] The idea that solidarity as beneficence requires us to help similar individuals regardless of how well-off they might be otherwise is a nice sentiment, and it is quite plausible when it comes to small matters of face-to-face helping – for example, I do not need to ask a stranger her bank balance before offering to share my umbrella or lend my phone (cf. Prainsack and Buyx 2012: 346-347). But it is less plausible when it comes to state assistance, where resource constraints and the need for public legitimacy and accountability require that we set priorities.

insurance prevents the system from being gamed in this way, protecting the system for all; thus, there is a strong argument in solidarity as mutual advantage for truly *universal* participation.

A second and perhaps broader problem for solidarity as beneficence is that it implies an overly narrow picture of the moral problems that need to be solved in devising and administering a universal health care system – and, relatedly, it lacks the internal normative resources for addressing those overlooked problems. For solidarity as beneficence, the fundamental problem of universal health care provision is simply one of assisting those in need. Whether or not we should agree that this represents the *fundamental* moral problem that a universal health care system must solve (and I argued in the previous section that we need not agree), it is clearly not the *only* problem. There is also a set of problems related to the allocation and rationing of scarce health care resources. It is difficult even to express these problems in the language of beneficence. At best, we might say that these problems show the need to set "limits to beneficence," which in turn suggests the need to appeal to further values or principles such as equality or overall utility; beneficence, after all, is not self-limiting.

Here again, solidarity as mutual advantage does not suffer from these same problems. From the point of view of solidarity as mutual advantage, rationing problems can be understood to invoke the same kinds of considerations that led us to establish a universal health care system in the first place – which is to say, the need to prevent free-riding in order to sustain a system of cooperation for mutual advantage. I argued in the previous section that the health care system can be understood as a system of cooperation that works via the pooling of health risks. But this pooling of risks involves at the same time a pooling of resources, in order to care for those individuals who eventually need care. In this way, sharing responsibility for health needs creates a kind of "commons," which in turn will be vulnerable to a version of the familiar *tragedy* of the commons – unless individuals are able to "stand together" to prevent such a tragedy from unfolding.

One way that such a tragedy arises in insurance contexts is by way of the phenomenon known as moral hazard. When a person is insured, her individual health care costs are in effect spread over the entire pool; she now has relatively little reason to moderate her own health care consumption or to exercise restraint in the pursuit of relatively low-value care. Indeed, an insured person who is ill now has very strong incentive to pursue almost any treatment, whatever the cost, even if she would not have been willing to pay the premiums necessary to cover the same treatment before she became ill. This, too, is a form of free-riding that can raise the cost of health care insurance for all, and there is a powerful argument in solidarity understood as mutual advantage for taking steps to limit it – perhaps by attaching co-pays or deductibles to certain kinds of care, to discourage unnecessary consumption, or even by refusing to pay for care that is not seen as cost-justified from a social point of view. From the point of view of solidarity as mutual advantage, this should be seen not as a matter of setting "limits to beneficence," but rather as a matter of protecting a shared resource against overconsumption for the sake of mutual advantage.

The foregoing remarks are just a sketch, of course, and are not intended to settle the question of how real-world decisions about rationing should be made.[26] My point here is only that starting from solidarity as mutual advantage leads us to see rationing questions as continuous with a broader picture of the normative logic of the health care system. For solidarity as beneficence, by contrast, such questions must be seen as not just *distinct* but also to some degree *opposed* to the primary aim of universal health care provision – which, after all, is supposed to involve sacrificing to assist others in need, not pinching pennies to deny care. And I would note in passing that, to the extent that the solidaristic health care systems of Western Europe are more effective at setting limits to care and

[26] For extended discussion, see Heath 2020: 228ff.

controlling cost inflation compared to the more market-oriented system of the US, that may explain some of the cost advantage the former enjoys over the latter (cf. Barr 1989: 73; Heath 2001: 188).

Solidarity as beneficence holds that our obligations of solidarity are obligations to assist fellow group members in need. While the view has obvious appeal, I have argued that it suffers serious problems in justifying anything like a universal health care system. Solidarity as beneficence pushes us toward seeing health care as a targeted benefit for the disadvantaged rather than a universal program, and it fails to even recognize, much less address, some important problems of justice in health care that do not fit neatly with the logic of beneficence. Solidarity as beneficence may suffer other problems as well, which I will only mention here. For example, according to solidarity as beneficence, why does the relevant assistance have to take the form of health care or health care insurance provided in kind, rather than cash assistance or something else a needy person might prefer? Why does the obligation to meet health needs fall on the "we" of a nation-state rather than on a smaller or larger collectivity, perhaps even a private entity? Hopefully, the broad strokes of the answers that solidarity as mutual advantage can offer to each of these questions will be clear from what has already been said. To my mind, it is not clear what solidarity as beneficence can say.

Even if the argument of this section so far succeeds, however, at best what it shows is that solidarity as beneficence is not by itself *sufficient* to undergird a universal health care system; something like solidarity as mutual advantage is necessary as well, in order to justify extending coverage to the well-off as well as the poor, and perhaps also to guide our resource allocation decisions. But here a partisan of solidarity as beneficence might suggest that solidarity as mutual advantage might face a similar problem: even if I have successfully shown that solidarity as mutual advantage (or something like it) is *necessary* to defend an adequate universal health care system, I have not shown that it is by itself

sufficient. And there is good reason to wonder whether solidarity as mutual advantage could ever be sufficient to justify an adequate universal health care system. After all, at least in a world marked by significant inequality such as ours, an adequate health care system must include not only universal coverage but also significant subsidies for the poor and sick by the rich and healthy. By subsidies I mean not just the ex post "subsidization" that is intrinsic to any insurance scheme, whereby those who suffer an insured loss are compensated by those who do not; hopefully it is clear from the foregoing that this poses no problem for a mutual advantage view. Rather, I mean subsidies that are apparent even ex ante, whereby more fortunate citizens pay an effective premium that far exceeds their expected health care costs, just in order that less fortunate citizens might pay less (or even, in some cases, that they might pay nothing at all). It is hard to see how these subsidies could be justified in the name of mutual advantage, since by their very nature they involve something like zero-sum redistribution rather than positive-sum cooperation. And yet these subsidies are obviously essential to any adequate and just health care system, at least in otherwise unequal societies like ours. For reasons like these, even if solidarity as mutual advantage must be part of the story of health care provision, it is hard to see how it can be the whole story (Dawson and Verweij 2012: 2; Ter Meulen 2015: 5-6).

In reply, I would begin by repeating that there is nothing in the nature of solidarity as mutual advantage that rules out a concern for fairness in the distribution of the benefits and burdens of collective action. Solidarity as mutual advantage is not the view that individuals should seek to *maximize* their own advantage; as I have said, that kind of ruthless self-interestedness is actually inconsistent with solidarity as mutual advantage, since that is precisely what gives rise to the free-rider problem in the first place. On the contrary, the principle that the strongest backs should bear the heaviest burdens is fully consistent with solidarity understood as mutual advantage, as the evidence of the labor movement will attest. Thus, solidarity as mutual advantage is not in principle incompatible with the subisidization of the poor and sick that we see in public insurance programs; properly understood, it may even require it.

If the subsidization of the poor by the rich is to pose a fundamental problem for the mutual advantage account, it could only be if the cost to the rich was so great as to take them outside of the realm of mutual advantage; it would be a problem, in other words, only if the cost to the rich was so great as to make them "net losers," so to speak, from their participation in the health care system. But a couple of considerations suggest that this is unlikely. For one thing, although rich people tend to pay more into public health care systems through taxation, they also tend to consume more in health care services over their lifetimes due to their own greater longevity compared to the poor; thus public health care systems are not as redistributive as they might appear at first glance (McClellan and Skinner 2006). For another, the rich also have more to lose from an adverse health event – not in terms of their health, of course, but in terms of the potential loss to their income and wealth. This suggests that, even if the wealthy might pay more for their insurance under progressive taxation, they also receive a more valued form of protection in return. And finally, it is possible to think of the progressive pricing of public health insurance as *itself* a kind of insurance, if one takes a suitably broad *ex ante* point of view. Given the declining marginal utility of money, individuals who did not know whether they were rich or poor would probably prefer a price scale that is sensitive to differences in ability to pay, since they would thereby maximize their own expected well-being going forward. In that way, sharing the risk of poverty, like sharing the risk of ill health, can in fact advantage everyone from a certain point of view. These considerations suggest that a conception of solidarity as mutual advantage may in fact have the resources all by itself to justify an adequate universal health care system, while solidarity as beneficence does not.

Conclusion

One recurring theme in discussions of solidarity is that relations of solidarity involve a sense of shared fate – a sense that what happens to one group member happens to all. Many theorists of solidarity are inclined to interpret this notion of shared fate as a form of beneficence. To share the fate of fellow group members is to be disposed to meet the needs of vulnerable group members for their own sake. Whatever the merits of this view in the abstract, I have tried to show that it fits imperfectly with the logic of national universal health care systems, which after all care for the vulnerable and the non-vulnerable alike.

An alternative is to interpret the notion of shared fate in terms of mutual advantage. On this view, we should be willing to share one another's fate because doing so benefits all of us. This is the conception of solidarity implicit in the quip commonly attributed to Benjamin Franklin at the signing of the U.S. Declaration of Independence: "we must all hang together, or most assuredly we shall all hang separately" (Isaacson 2003). If it is difficult to see how Franklin's quip amounts to a genuine *moral* view, that is only because it is expressed in the plural. Translated into the singular – "*I* must hang together, or *I* will hang separately" – we see that it presents a false dilemma; it ignores the free-riders' hope of doing neither. This is why "hanging together" requires the acceptance of real constraints on a person's own self-interest; this is why it calls for true *solidarity*.

I have tried to show that the defense of universal health care provision offered by this form of solidarity is both compelling and complete. Shared responsibility for health care needs benefits all in that it protects all of us from the vagaries of chance and enables us to meet the future more effectively.

Solidarity as mutual advantage holds that we must all hang together to prevent those advantages from unravelling.

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