Norman Schofield · Gonzalo Caballero · Daniel Kselman *Editors*

Advances in Political Economy

Institutions, Modelling and Empirical Analysis

This book presents latest research in the field of Political Economy, dealing with the integration of economics and politics and the way institutions affect social decisions. The focus is on innovative topics such as an institutional analysis based on case studies; the influence of activists on political decisions; new techniques for analyzing elections, involving game theory and empirical methods.

Schofield · Caballero
Kselman *Eds.*

Advances in Political Economy

Norman Schofield
Gonzalo Caballero
Daniel Kselman *Editors*

Advances in Political Economy

Institutions, Modelling and Empirical Analysis

Springer

Social Sciences / Political Science

ISBN 978-3-642-35238-6

▶ springer.com

EDITOR'S PROOF

In addition to the Constitutional principal and the policy-setting principal, there is also the stage of implementation of the policy, and the contract enforcement at the implementation stage is also conducted by the principal or some authorized representative thereof. If, for example, a patient has no assets to cover a life saving or life extending treatment, it is up to the medical provider on site to deny her care if that is what the contract calls for, and a doctor or a hospital in that case unilaterally represents the societal principal.

In a sense, we have three different personifications of what colloquially is treated as the same actor in matters of welfare provision. Multiple personifications however imply separate actors with distinctive preferences and potentially conflicting interests. Our model exposes the implications of these conflicting interests within different institutional structures.

The three types of actors representing the societal principal are labeled below as EAP, IP, and PP. An Ex-ante Principal, EAP, acts at the constitutional stage. An Interim principal, IP, depending on the constitutional choice, can be either majoritarian or by unanimity (IPM or IPU). Notice that the by-unanimity interim principal is comprised of the same people but differs from the ex-ante principal by the level of information that members of the society have about their own types and the distribution of types in the population. Finally, at the implementation and enforcement stage, there is the Ex-Post Principal, PP.

All four (counting both IPM and IPU) actors representing the principal, we claim, share the basic preferences as postulated by Kornai and Eggleston (2001) which we discussed above.

2.1 The Ex-ante Rawlsian Principal

Rawls's premise and Kornai–Eggleston's assumptions have been historically appealing to scholars of political economy. Hayek has argued as far back as 1945 that:

> There is no reason why, in a society which has reached the general level of wealth ours has, the first kind of security should not be guaranteed to all without endangering general freedom; that is: some minimum of food, shelter and clothing, **sufficient to preserve health**. Nor is there any reason why the state should not help to organize a **comprehensive system of social insurance** in providing for those common hazards of life against which few can make adequate provision. (emphasis added, Matthews 2010)

Fuchs (1996, 16) also states that medical care meets Adam Smith's 1776 definition of a necessary—in that it is necessary to sustain life and that it is indecent for even the lowest people in society to be without it.

Insofar as the total (or average) cost of the policy is concerned, we assume that the constitutional principal, EAP, prefers it minimized as long as acceptable outcome is achieved with regard to care. Provision of healthcare at some level viewed as adequate is the first priority, while cost-minimization is secondary. We stay away from

UNCORRECTED PROOF

EDITOR'S PROOF

Table 1 Utility functions of the four types of principals

	Minimal adequate care	Personal tax burden	Societal cost (average tax burden)
EAP	Yes		Yes
UIP	Yes	Yes	
MIP	Yes	Yes	
PP	Yes		

the discussion of whether it is possible to view as minimally adequate a level of care that the society cannot afford (there is research to suggest that the notion of what is adequate may vary, to a point with the societal wealth, see Attfield (1990), Blank and Burau (2006), Howell and McLaughlin (1989)). Also, given the Kornai–Eggleston assumption of lexicographic preference for basic care provision, we do not include in consideration any surplus care beyond what is minimally adequate and make no additional assumptions about individual and societal preferences for that.

Table 1 summarizes the composition of the EAP's utility function, and also highlights the distinctions in the utility functions of the actors-principals. We elaborate on these differences below.

2.2 Interim Principal—The Policy-Setting Body

Our interim principal is a coalition of individuals in the society of the size and composition as empowered by the constitution to be decisive on the fundamentals of the healthcare policy. It chooses the contract with the agent-patient which constitutes the healthcare policy. The choice of the contract/policy can take place anywhere from a constitutional body or a referendum to a legislative chamber or even the local government, depending on the rules in place. Importantly, only under unanimity, the set of members of the decisive coalition for policy is fixed at the outset as the entirety of the society. Under all other rules, the membership of the decisive coalition is endogenous to the policy choice and thus a pair: (specific policy choice; specific make-up of the decisive coalition) must be an equilibrium outcome of the interaction according to the rules of the decisive body.

In Fig. 2, we compare side by side the process of policy making and implementation where the venue for policy choice is a constitutional (unanimous) body versus a legislature with simple majority rule (the UIP or MIP respectively). Be it unanimous or majoritarian, the interim principal offers the patient/agent a contract of some sort. The contract might be: "we are going to automatically withhold a portion of yours and everyone else's earnings, and in return we assume the responsibility for taking care of your health." Something like that would effectively mean the entitlement single-payer system. Or a contract might read: "You can buy as much health coverage as you choose, either directly from providers at point of service, or by means of purchasing a specific amount and type of health insurance. You will be provided only with the services which either you or your health insurance can finance and

UNCORRECTED PROOF

EDITOR'S PROOF

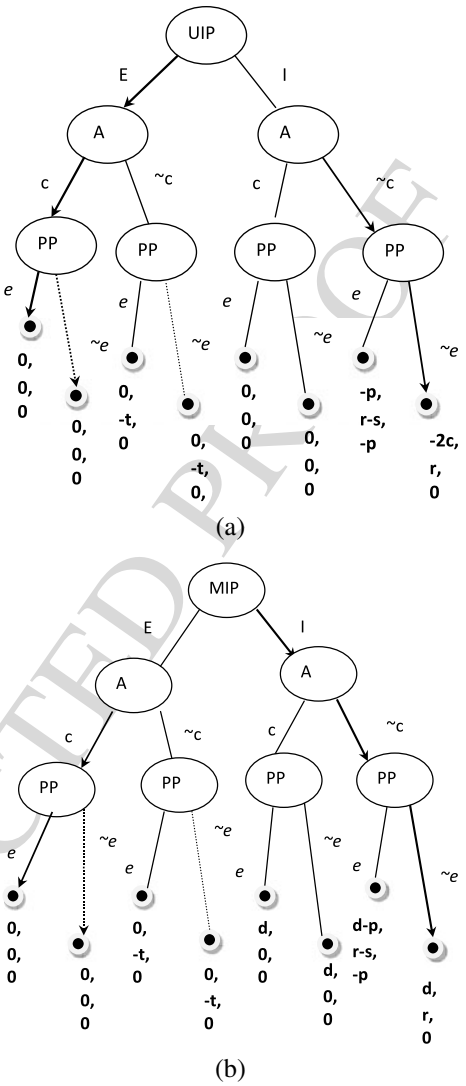

Fig. 2 (**a**) Decision by unanimity: Some members of the decisive coalition will have to finance the case of the individual non-compliance/public non-enforcement. (**b**) Decision by majority rule: Members of the decisive coalition are exempt from taxation to cover the costs in the case of the individual non-compliance/public non-enforcement

nothing beyond that, regardless of your health needs." This would be the contract behind an ideal type of a pure market private insurance system. In the model in Fig. 2 we limit ourselves with these two extreme types of policy choices, though in practice the full range of in-between options might also be available. While all contracts have their implementation issues, below we show that the latter is fundamentally non-enforceable, yet even knowing it to be non-enforceable, decision bodies of certain types would choose to adopt such a contract.

The utility function of a citizen as a member of an interim principal is more specific than that of the EAP in regards to which costs become the part of the calculation. Notice, that the contract/policy necessarily must include the a) the funding

UNCORRECTED PROOF

EDITOR'S PROOF

principle, b) the level of services (only covered or all that is necessary), and, c) also must stipulate the fallout provisions, as in what to do when there is a cost overrun. We claim that such provisions are indeed in place, through the access to the general state budget, and that they are implied within the broad constitutional framework of the state. We will thus assume that any shortfall which might arise from enforcement failure is made up from regular taxation, where the general tax burden is allocated via the majoritarian process. From that our actors who know what share of the tax burden they bear can form expectations about the share of the cost overrun that will fall on them if the enforcement of the contract/policy fails.

2.3 Ex-post Principal at the Contract Implementation Stage

At the time of enforcing the market-type contract/policy, the ex-post principal is a citizen in a position of authority who acts on the society's behalf, such as a doctor or administrator in an emergency room where an uninsured patient shows up. This individual then has to make a decision on whether or not to treat the patient who is in breach of a contract. It has been long claimed that at this stage the market-type contract goes unimplemented: though patients cannot pay and have failed to carry sufficient medical coverage, they receive the treatment which ought to be denied to them according to the rules, including treatment for not immediately life-threatening conditions. Providers thus incur costs which they cannot recoup from these patients, and such costs, in one way or another, are eventually transferred to be covered by the society at large, either by overcharging the paying patients or through infusions from state budget. This observation is consistent with our assumption that the principal adheres to Kornai and Eggleston's premises. Specifically, PP holds a preference to treat the patient and to not deny care to the poor which he would be able to offer to the rich. IP, in a position to sanction PP most severely, in turn prefers not to do that because the alternative outcome for the patient—her continued sickness or death—is considered even worse by the IP as well. This could be the last move in games in Figs. 2a and 2b, but we leave it unmodelled for it is redundant given the assumed preference of the principal. This redundant move by UIP or MIP is sufficient to justify the use of state budget to cover cost overrun. The last resort access to state budget follows logically from the Kornai–Eggleston assumptions.

In the model's terms, then, the ex-post principal, PP, has the choice at the last decision node to *enforce* or *not enforce* a contract (in the case of *Entitlement*, the contract is enforced via taxation, so there the move by PP that we show is redundant[3]). These choices, e versus $\sim e$, apply under *Insurance* health policy to enforcing the implied "no-care" policy for those without purchased adequate coverage and without sufficient private funds to cover the cost of treatment. Parameter $-p$ in the PP

[3]The choice to enforce or not to enforce the "no care" provision reappears where the entitlement is not universal, and might apply, for example, when the treatment of immigrants/non-citizens is concerned.

UNCORRECTED PROOF

EDITOR'S PROOF

payoff captures this utility loss from having to deny a patient needed care because of his or her failure to pay or carry insurance. It captures Kornai's premises, and as it applies to every individual in the society, it is felt by the ex-post principal, but it is also present in utility functions of other actors-principals, EAP, UIP, and MIP. They all sustain loss if care is indeed refused to a patient.

The Agent (patient) values her health and wants to receive care if sick. But generally she does not like to bear the costs according to the contract/policy. In reality, the agent sometimes is financially unable, not just unwilling, to bear the cost of a serious treatment or of an insurance that would cover such treatment—but that consideration calls for a separate, normative argument, and so we do not include that possibility in our model. Here, the agent abides by the contract choosing between c (*comply*) and $\sim c$ (*not comply*). To *comply*, depending on a subgame, means either to pay the social tax or buy enough insurance (zero may be enough if no treatment is sought). To *not comply* in a single-payer system requires that the agent stays out of the workforce, and her payoffs reflect that. In a market-type system, *not complying* consists of two components: how much coverage one has purchased and how much care she is requesting. Thus, to *comply* means to ask for care in the amount the patient/agent has covered. To *not comply* means to ask for care in excess of what she can pay for.

The decision to not comply in the Entitlement case is strictly dominated for the agent since it equals non-participation in employment thus escaping universal tax. This is indicated in Fig. 2 by the utility loss of $-t$ due to the loss of wages. Generally, we stay away from the problem of enforcing tax collection, thus de-facto assuming that tax collection is enforced. The same, however, is not the case with *compliance* under the market-based policy. Not buying insurance does not by itself constitute non-compliance, and therefore cannot be punished or otherwise enforced. The contract can be enforced only at the point of service, when denying care to a sick uninsured patient who chose to request care. If the contract is enforced, the agent sustains a catastrophic utility loss from avoidably getting worse, a decline in the quality of life, or from dying. If on the other hand the contract is not enforced by the PP and care is provided, then no such utility loss to agent occurs while no contribution to financing the care is made by the agent-patient.

3 Health-Related Technology and Costs to Actors

3.1 Extra Cost of Delivering Health Care as Emergency Care

In Fig. 2, $c > 0$ captures the financial efficiency loss from substituting emergency care for preventative and regular care. Scholars of healthcare consider it a major objective to determine whether similar health outcomes can be reached with greater efficiency under some medical "technology" compared to others. Specifically, a substantial consensus has developed that investment in preventative measures generates much better returns than that in high-end life-saving medicine (see Halfon and

UNCORRECTED PROOF

EDITOR'S PROOF

Hochstein 2002, among others). This effect is potentially explained by the fact that consistent preventative and regular care reduces the instances of having to save lives in emergencies (Institute of Medicine 2002).

If we accept the tradeoff in favor of preventative medicine as efficient, then logic dictates that the principal who is willing to pay for emergency procedures should be willing to pay for the cheaper preventative medicine as it replaces at a lower cost some of the eventual emergency medicine. Put plainly, since we are willing to pay (and are paying) for the latter, we should be willing to replace a part of that with "regular" care, since regular care is cheaper than treating the share of emergencies that it will prevent. There is even a possibility that regular and preventative care may boost the productive resources of the society (Bloom and Canning 2000) and generate a net surplus, thus paying for itself twice.

So combining the premise of preference for saving lives in an emergency with the technological fact that emergency care is more expensive than regular care as its substitute, we must conclude that the principal prefers the outcomes where regular and preventative care is consistently applied.

Summing up the discussion of the aspects of medical technology that affect the overall cost to the principal, we can conclude that the information that we have about the aims in the social welfare function and the cost structure in the medical field lead to the prediction that the overall cost to the principal is minimized when the outcome is that all have preventative and regular care, and when health is financed in a society-wide "insurance" or other redistributive pool.

3.2 Marginal Costs of Healthcare Are Increasing

Technology aspects bearing on the costs to agent/patient add further complexity. Having mentioned earlier the possibility of paying with private funds for care, we mentioned that such funds are unlikely to be available (with the exception of very few individuals) when it comes to urgent need for specialized and critical care. Here is the right place to elaborate why that is the case, and consequently why the financial transfers from the healthy to the sick are a present-day necessity. They are necessary, and it is pure luck that, according to Kornai and Eggleston (2001), the collective principal has preferences consistent with authorizing those transfers.

For almost any individual or family, as the costs of medical innovations and life-saving procedures rise, as is implied by the technological characteristics of medical innovations, the cost of treatment *if* one actually becomes very ill exceeds the ability to pay.

The distinctive nature of healthcare as a good, another technology-related aspect, accounts for the second-order market failure following the first-order market failure as described above. Where with any other good the financial markets would make the resources available, and the price of credit would be bolstered by the strength of the individual's demand for such credit, with financing health this approach fails. This is because in financing healthcare a lender would be financing the "investment"

UNCORRECTED PROOF

EDITOR'S PROOF

in the survival and the subsequent earning ability of a sick individual—the greater the demand for funding, the sicker the individual and, so to speak, the weaker the "collateral."

The view that individual savings can become a means of financing health care is similarly fallacious for related reasons. A large number of the sickest patients are sick because of genetic or related to genetic predispositions reasons and thus need expensive care when they are younger than the wage-earning age. Moreover, this view once again fails to account for the peculiarities of health as a good. The costlier variety of health care is demanded by the sickest individuals in a society—by precisely those who encounter additional difficulties in developing their earning capacity in the knowledge-based economy and present high risk as potential hires. And later in life, once an illness strikes, maintaining one's career can be near impossible even for high-earning individuals. Finally, almost a necessary precursor to high earnings in a modern economy is accumulation of massive debt—not savings—during the stage of professional education and early career development, which excludes a large portion of the demographics from the ability to accumulate savings of sufficient size to fund a serious treatment.

A combination of failure to purchase adequate amount of insurance, not having enough ready money, and getting sick and requiring treatment falls in our category of non-compliance with the market-type health contract/policy as in Fig. 2. In our abstract representation, it is up to an individual to decide how much insurance or care to purchase, as long as she does not attempt to receive anything beyond what she paid for. In other words, one can look at the situation from the following angle: *asking* for treatment for which you are not eligible under this form of the social contract is what constitutes non-compliance by the Agent (patient).

3.3 Is Consumption of Healthcare Peculiar?

The next question that we need to ask ourselves as we generate the payoff functions for our model is to what extent and when is the demand for healthcare elastic? Pauly (1986) revisits the application of the economic model of insurance to health care to argue that tax subsidies to health insurance create incentives to overuse health care. He argues that moral hazard plays a strong role in medical insurance. Here, moral hazard can either occur when the presence of health insurance causes the insured person to spend less on preventative care—i.e. to take greater risks because the of certainty of coverage in the event of an illness—or it occurs when the purchase of insurance causes a person to spend more to treat an illness than that person would have spent without the insurance. (1986, 640) As an example, Pauly cites data showing that people who are insured for only part of the year use ambulatory care twice as much while insured than while uninsured. (1986, 636). He assumes that the relative lack of care while uninsured indicates the true value of health care for this group—thus the care consumed while insured constitutes overconsumption.

The moral hazard notion has a number of critics. A RAND corporation experiment notes that high levels of co-pays for health insurance will induce people to use

UNCORRECTED PROOF

EDITOR'S PROOF

less health care, but not necessarily in an efficient way (Gladwell 2005). Many of the services they neglected were necessary and using them could have decreased, rather than increased, overall costs. In a popular article, Gladwell (2005) thus portrays the real-life choices many lower income people make in health care consumption:

> Steve uses less health care than he would if he had insurance, but that's not because he has defeated the scourge of moral hazard. It's because instead of getting a broken bone fixed he put a bandage on it.

Gladwell's numerous colorful examples show that, rather than revealing low utility for health care, many choose not to purchase health insurance because that purchase would make it impossible for them to purchase anything else. If this is the case, then we must be careful to not let concerns regarding misuse of medical care be inflated in assessing efficiency.

This elasticity, manifested in reduced demand below some basic level of necessary care due to agent's inability to pay, is contrary to the principal's preferences, and therefore a decrease in demand for these reasons decreases the principal's utility, costs notwithstanding. And it might not even reduce the costs: Currie and Gruber (1996) explore the effects from the extension of Medicaid services to a larger proportion of people. They note that, consistent with Pauly's findings, following the increased opportunity to use health services, a larger number of people made use of them. They also note that this use was beneficial—child mortality decreased significantly. In terms of efficiency, they argue that the cost per life saved was lower than the typical "value of a human life"—or that the benefits of the Medicaid extension were higher than the costs. This is consistent with the claim that access to regular care is less costly than reliance only on emergency care.

Another aspect of moral hazard with agents-patients arises when they do not put enough effort in preventative care and so eventually run up the cost of treatment by developing advanced diseases or acute problems. However, since they are unlikely to delay seeking treatment when they have coverage as compared to those who are uninsured, this possibility merely has the potential to wipe out some of the cost gains. Yet one more instance of moral hazard is when patients fail to select the cheaper and more efficient providers and treatments out of available alternatives. This can be addressed by incentive schemes in a straightforward way. To encourage the use of preventative care which may be personally costly in terms of time and effort, the principal may choose to reward desirable behavior of individuals. When it comes to encouraging economical use of health care resources, health care structures must provide incentives.

4 Health Policy Choice: Entitlement Versus Market (Insurance-)Based Contracts

We simplify the field of healthcare provision mechanisms to two stylized policy extremes between our policy makers who will be choosing using their constitutionally decided decision rule: the entitlement mechanism with automatic flat tax

UNCORRECTED PROOF

EDITOR'S PROOF

versus fully individualistic purchase (of either healthcare of health insurance). The Entitlement policy is the single payer guaranteed basic care provision funded with a universal tax on all workers (a system like the funding of Medicare and Social Security). The single payer system generally collects taxes from the population and uses that money to fund universal health care for its population. On the one hand, it maximizes the size of the risk pool, and on the other hand it requires making resource allocation decisions that would allow the resource expenditures over the entire population to fit within the budget constraint. Both of these aspects of the *Entitlement* policy choice are outside of our analytical framework here. We do not rely in our conclusions on assuming that population wide risk pool improves financial solvency of the system, nor do we address the decision by the principal of what healthcare services and under what circumstances must be provided to each person.[4]

4.1 The Model

Our model analyzes the choice of policy coverage using backward induction. In Fig. 2a, we depict the choices made using unanimity rule. In this situation, the UIP must decide between health care as an *entitlement*, E, or through private (*insurance*) purchase, I. Next, the Patient/agent, A, either *complies* (c) or not ($\sim c$) with the requirements of either coverage scheme. Finally, the PP chooses whether to *enforce* (e) or not ($\sim e$) the rules of the given coverage scheme at point of service.

Moving now to the stylized model of constitutional and policy choice, payoffs in Fig. 2 to all three actors-principals reflect their preferences for delivering health benefits according to Kornai and Eggleston (2001). The other model's necessary component is the allocation of costs within the principal, and payoffs to EAP, UIP, MIP, and PP reflect those costs as they are born by each particular type of a player. A contract that the principal chooses consists of a funding scheme and of the guarantee of the delivery of the good (healthcare), which may or may not be a function of the agent's contribution to funding. Due to the lexicographic preferences in the polity, the budget constraint within the health policy area is soft and provision does not have to cease when designated funding is depleted.[5] This is not an ad hoc assumption but follows from the presumed preferences of the PP and the nature of the enforcement process. In short, it is this assumption that identifies the particular case of collective action problems that we address.

In this essay we choose to treat the soft budget constraint in regard to health as an assumption, but it could be viewed a part of an equilibrium strategy of the principal who, among other things, could be asked to decide whether or not to hold the budget

[4] For arguments regarding the relative efficiencies of single payer versus private insurance systems, see Sieberg and Shvetsova (2012).

[5] As noted by a reviewer, the terms 'soft constraint' appears to be an oxymoron. We use the term here to distinguish between the intended constraint on health care spending determined by private purchase and the extra spending, that must covered by taxation, because the principal is unwilling in the end to let the people pay the price for their own decisions.

UNCORRECTED PROOF

EDITOR'S PROOF

constraint as firm at a price of human lives or health. The source of additional funds presumably is the national budget, where the budget constraint is firm but one could allow for borrowing against the next period or redistributing from other spending areas.

Thus, to make up for the potential shortfall in the area of healthcare, in parallel, and in the background, there is a nesting policy of general taxation addressed in the extant literature discussed in the next section. General taxation to cover any care that was provided but not purchased, we here assume, is always decided by majority.[6] Thus we can fall back on the results on the median voter tax preferences.

Constitutional choice for policy procedure that we model applies only to the area of healthcare. But actors in their decisions are cognizant that it takes place under the expectations generated by majoritarian general taxation and this factors into their expected payoffs. We show that the majoritarian procedure leads to exploiting the state budget in lieu of designing an efficient policy-specific financing mechanism. The combined (health policy-designated budget, plus cost overruns covered from general taxation) funding mechanism will be more equitable if the decision is made by unanimity, and will end up more redistributive when the decisive coalition diminishes in size (e.g., under majority). This is because when the contract is designed by (ex-ante) unanimity (as in the case of UIP in Fig. 2a), there does not exist a minority outside the decisive coalition which could be legally obligated to disproportionately finance the policy (or as may be the case in the US, its cost overruns), so every person will have to agree to bear a part of the burden.

4.2 The Median Voter Theorem and Majoritarian Taxation

While the taxing decision is not included in the extensive form in Fig. 2, it is certainly implied and must be accounted for in the payoffs of the interim principals both in Figs. 2a and 2b. Under a private insurance system, individuals will purchase a certain amount of coverage, beyond which they should not get treatment. However, there is a contingency where the ex-post principal will not deny treatment in the case of need. If, ex-post, these unfunded expenses are covered from general taxation, agreed on by majority rule, then majority preference over healthcare policy that generates budget overruns will depend directly on how much of this excess burden is borne by the median voter.

Scholars of fiscal policy (see, e.g., Meltzer and Richard 1981, 1983) rely on the premise that median income is way below the mean of the income distribution and thus redistributive taxation by majority is enabled. The voluminous body of literature predicts it to be placing the chief burden of taxes on the wealthy minority. In a population with an income distribution that is skewed towards the left, the

[6] In general, taxes can be used to fund a host of services, projects, redistribution schemes, etc. To avoid complication, we merely address the issue of taxation to finance extra health care spending here.

UNCORRECTED PROOF

EDITOR'S PROOF

median voter has a lower income than the mean voter. This voter, then, has more incentive to demand redistributive taxation (see Rosenthal and Eibner 2005, Nelson 1999) because she bears less of the burden. Holcombe and Caudill (1985) show that the median voter can bear no tax burden at all. In this case, the median voter prefers an insurance system in which she pays only for her own insurance, and wealthier voters pay for the care of those who need care beyond their level of coverage. If this holds, then a healthy median voter would pay less under an insurance scheme than with *Entitlement*; thus her payoff for *Insurance* is d which is greater than or equal to the baseline payoff of 0. This idea is consistent with other research on the link between the median voter's tax share and social spending. For example, Corcoran and Evans (2010) find that a reduction in the median voter's tax share induces higher local spending on public education. Thus the expectation of the majority coalition on the dimension of general taxation is zero personal contribution to paying for the cost overrun on healthcare.

4.3 Median Preferences on Healthcare Policy

The next step to identifying the payoff to MIP is to see what the median on healthcare dimension expects to pay and to receive. Adding the premise that the distribution of health is skewed similarly to that of wealth but in the substantively "opposite" direction, we assume that the mean "level of sickness" is above the population median, meaning that most healthcare costs (due to the costly specialized care and severe disability maintenance) are demanded by a relatively small minority of the population.

As an illustration, consider a hypothetical example with binary types in the population on each dimension. Suppose, to keep it simple, that individuals who comprise the principal at the interim stage know their health type as well as their wealth type, and the probabilities are .2 of the wealthy type on the dimension of wealth, and .2 of the sick type on the dimension of health. Then the joint distribution in the voting population deciding on healthcare policy given that cost overruns are made up from general taxation becomes as in Table 2.

Notice in the illustration in Table 2 that in this rather extreme case 64 percent of the electorate will not need to pay anything for their own healthcare AND are not going to be in the fiscal pool for general taxation. Relatively to the baseline payoff from *Entitlement* policy, with its uniform tax, they are thus saving some positive amount d, as reflected in the payoffs to the MIP in Fig. 3.

In real circumstances, the distributions of health and/or of wealth might be relatively more centered, yet the coalition with preference for *Insurance* might still

Table 2 A hypothetical distribution of types in the electorate

	Poor	Wealthy
Sick	.16	.04
Healthy	.64	.16

UNCORRECTED PROOF