Appeals to individual responsibility for health: reconsidering the luck egalitarian perspective

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1. INTRODUCTION

In recent debates about the distribution of health care resources, the notion of individual responsibility has received an increasing amount of attention, in philosophical discussions,[1] health policy documents,[2] as well as public debates.[3] On the one hand, the suggestion that individuals should be held responsible for health care costs that can in some way be attributed to their own choices has become a controversial aspect of the debate about health resource allocation and rationing. On the other hand, there have also been (less controversial) suggestions that individuals should be encouraged to take greater responsibility for their health so as to avoid diseases that result from, or are made more likely by, certain behaviours. In the theoretical debate on this issue, luck

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[1] In addition to the references below, see Wikler, D. Who should be blamed for being sick? *Health Education and Behavior* 1987;14:11-25, Wikler, D. 1987. Personal responsibility for illness. In *Health Care Ethics: An Introduction.* D. Van De Veer & T. Regan, eds. Philadelphia: Temple University Press: 326-358.

[2] For example, an emphasis on individual responsibility has been identified in recent policy documents in the UK: Smith et al. note that, around 2003, there was a shift from a focus on social and material factors, such as social exclusion or housing, towards 'lifestyle choices' as causes of health inequalities and areas on which policy interventions should focus; Smith, K, Hunter, D, Blackman, T, Elliott, E, Greene, A, Harrington, B, et al. Divergence or convergence? Health inequalities and policy in devolved Britain. *Critical Social Policy* 2009;29:216-242. See also Hunter, D. Choosing or losing health? *Journal of Epidemiology and Community Health* 2005;59:1010-1013.

[3] E.g., on media representations of obesity, see Saguy, A & Gruys, K. Morality and Health: News Media Constructions of Overweight and Eating Disorders. *Social Problems* 2010;57:231-250.

egalitarian theory, which emphasises the distinction between 'chance' and 'choice' in determining equal distributions, is often drawn upon.

This paper considers three kinds of appeals to responsibility that feature in these debates: First, individual responsibility is sometimes taken to play a role in rationing decisions, providing a criterion for denying treatment, according a lower priority to, or requiring a greater financial contribution from patients who are deemed 'responsible' for a specific health need. Second, a number of policies have introduced incentives of various kinds to encourage individuals to 'take responsibility' for their health. Finally, a number of recent policy documents as well as contributions to the philosophical literature have included appeals to individuals to act 'responsibly' with respect to their health and the health care system, connecting such appeals with a discourse about fairness and reciprocity.

The aim of this paper is two-fold. First, I raise concerns about the ways in which the idea of personal responsibility has been used in debates about health policy. The use of individual responsibility as a rationing criterion has already been criticised widely in the literature. The response to health incentives, however, has been somewhat ambiguous, while reciprocity-based appeals to responsibility that are detached from the use of material incentives have, as yet, received little attention from philosophers. In attempting a first assessment of these uses of the idea of responsibility, I will be particularly concerned with considerations of equality, which are a longstanding concern in health policy and particularly salient to the issue at hand. I will be drawing on relevant debates in egalitarian theories of justice, and in particular luck egalitarian approaches to equality. In doing so, this paper pursues a second objective: to re-evaluate

the policy implications of the luck egalitarian approach in light of recent developments in the literature. As I explain below, luck egalitarians can provide a more nuanced position on individual responsibility for health than is assumed by many of its critics. Furthermore, luck egalitarians are likely to be critical of appeals to responsibility that, on other theories of social justice, would be unproblematic, highlighting concerns about the impact of such appeals from the perspective of equality.

The paper begins by setting out the main points of the luck egalitarian approach and its application to the health arena (section 2). Section 3 sets out the luck egalitarian's response to arguments that use individual responsibility as a rationing criterion. In section 4, I consider the use of incentives to encourage individuals to 'take responsibility' for their health. Section 5 addresses arguments that link appeals to individual responsibility with notions of reciprocity. Section 6 moves from specific appeals to individual responsibility to a more general concern about the language of individual responsibility and its possible impact on individual well-being and health.

2. LUCK EGALITARIANISM AND HEALTH

Luck egalitarianism is a recent theory of equality, different versions of which were first developed by Ronald Dworkin, G. A. Cohen and Richard Arneson.[4] In recent years, the implications of this theory for the health context have also been examined, most prominently by Shlomi Segall.[5] The basic theoretical framework put forward by luck egalitarians stipulates that inequalities are fair if and only if they are the result of

[4] Dworkin, R. What is equality? Part 2: Equality of resources. *Philosophy & Public Affairs* 1981;10:283-345, Cohen, GA. On the currency of egalitarian justice. *Ethics* 1989;99:906-944, Arneson, RJ. Equality and equal opportunity for welfare. *Philosophical Studies* 1989;56:77-93.

[5] Segall, S. 2009. *Health, Luck, and Justice*. Princeton, NJ: Princeton University Press.

choices for which agents can reasonably be held responsible. In addition to questions about responsibility, which are the focus of this paper, two aspects of luck egalitarianism are particularly salient to the health context: the metric in which equality is to be measured and the scope of unfair inequality.

First, luck egalitarians must decide in terms of which metric individuals' positions are to be compared. Much of the early literature on luck egalitarianism was devoted to this question. Two main contenders have emerged from this debate. On one account, we may compare people's positions in terms of resources, where this notion can be understood broadly so as to include 'internal' resources such as talents and abilities; the main proponent of this approach is Dworkin.[6] Alternatively, we may compare people's positions in terms of welfare, which could be interpreted, for example, as preference-satisfaction or in terms of an objective list account.[7] Particularly important for the present context is that the literature assumes that the relevant considerations can be captured within *one* metric (be it resources or some version of welfare). This means that, unlike other theories, luck egalitarianism does not attach a special role to health; rather, health is captured in terms of (its effects on) whatever currency is chosen.[8]

Second, while much of the critical literature has focused on inequalities that luck egalitarians purportedly find unproblematic, in at least two respects luck egalitarianism implies a more expansive approach to inequalities in health than many other accounts of

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[6] E.g. Dworkin, 1981, op. cit.

[7] Arneson, 1989, op. cit, Arneson, RJ. Liberalism, distributive subjectivism, and equal opportunity for welfare. *Philosophy & Public Affairs* 1990;19:158-194, Arneson, RJ. Welfare should be the currency of justice. *Canadian Journal of Philosophy* 2000;30:497-524.

[8] Potential problems arising from this feature of the luck egalitarian approach are discussed in Daniels, N. 2008. *Just Health: Meeting Health Needs Fairly*. Cambridge: Cambridge University Press, ch. 2.

justice in health. Luck egalitarians typically reject three criteria that many other theories of justice rely on in drawing the line between fair and unfair health inequalities.

First, the luck egalitarian framework stipulates that inequalities can be unfair irrespective of whether or not the source of, or causal history leading to, the inequality is in itself unjust. This means, most prominently, that biological or 'natural' sources of inequality are, from a luck egalitarian perspective, just as problematic as inequalities that are the result of social factors, such as unequal treatment or an unfair distribution of the social determinants of health. As Arneson notes, 'Disadvantage due to social arrangements has the same fundamental moral status as disadvantage due to natural causes like bad weather.'[9] For this reason, Segall argues that luck egalitarians must consider the difference in life expectancy between men and women that is found, to greater or lesser extent, in most parts of the world, unfair, even to the extent that it is the result of biological rather than environmental factors.[10] This distinguishes luck egalitarianism from, for example, Whitehead's influential account, which emphasises that differences due to '[n]atural, biological variation'[11] cannot be sources of unfair inequality. This approach still informs much policy work on justice in health, such as the WHO's.[12] Similarly, Daniels' influential account of justice in health distinguishes

[9] Arneson, RJ. 2011. Luck egalitarianism - a primer. In *Responsibility and Distributive Justice.* C. Knight & Z. Stemplowska, eds. Oxford: Oxford University Press: 24-50.
[10] Segall, 2009, op. cit.
[11] Whitehead, M. The concepts and principles of equity and health. *Health Promotion International* 1991;6:217-228.
[12] E.g. World Health Organization. 2007. *Ethical considerations in developing a public health response to pandemic influenza*. Geneva: World Health Organization.

fair from unfair inequalities according to whether or not they were caused by an unjust distribution of the social determinants of health.[13]

Second, some theories of justice distinguish between inequalities according to whether they are controllable, in the sense that they could have been avoided and/or are amenable to intervention. Daniels, for example, notes that '[t]o the extent that [the] social determinants [of health] are socially controllable, we clearly face questions of distributive justice'.[14] This criterion is influential in the policy world. The recent Report by the Commission on the Social Determinants of Health states that '[w]here systematic differences in health are judged to be avoidable by reasonable action globally and within society they are, quite simply, unjust. It is this that we label health inequity'.[15] Norheim and Asada argue that 'the relevant distinction is whether the institutions of society can respond adequately to a disease or not'.[16] In support of this proposal, they suggest that the availability of technology and treatment options will affect whether a particular inequality would be considered unjust:

> people dying prematurely from HIV/AIDS in the early 1980s (before the aetiology of the disease was known) were suffering tremendously, but their tragically reduced life expectancy was not unfair. Given the medical advancement for HIV/AIDS treatment in recent decades, however, the same amount of suffering and premature death now is quite rightly considered inequitable.[17]

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[13] Daniels, 2008, op. cit.
[14] Daniels, 2008, op. cit.
[15] Commission on the Social Determinants of Health. 2008. *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*. Geneva: World Health Organization: 26.
[16] Norheim, O & Asada, Y. The ideal of equal health revisited: definitions and measures of inequity in health should be better integrated with theories of distributive justice. *International Journal for Equity in Health* 2009;8:40.
[17] Norheim & Asada, 2009, op. cit.

From a luck egalitarian perspective, in contrast, health inequalities can be unfair even if there is nothing that can be done to prevent or address them.[18]

Unlike proponents of other approaches to justice, then, luck egalitarians do not see a normatively relevant distinction between 'natural' and 'social' inequalities in health, and they do not think that our ability to prevent or address specific inequalities should affect our judgement about their unfairness. Does this make luck egalitarianism a more appealing theory, or does it provide further objections to luck egalitarianism? I do not argue for either view in this paper.[19] However, the discussion highlights that even the debate has focused on health inequalities that luck egalitarians cannot regard as unfair, there are types of health inequalities that they, but not proponents of other approaches, regard as problematic.

3. OPTION LUCK VS. BRUTE LUCK: INDIVIDUAL RESPONSIBILITY AS A RATIONING CRITERION

Luck egalitarians are often criticised for their purported harshness in responding to individuals who, as a result of choices they have made or failed to make, find themselves in desolate circumstances. Within the health context, luck egalitarians are frequently cited as supporting policies that would refuse treatment to, or hold otherwise responsible, individuals whose ill health can be traced back to their own behaviour or

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[18] A possible exception here may be Dworkin, whose approach can be interpreted as requiring that inequalities cannot be unfair if we do not have the means to remedy them; see Williams, A. Equality, ambition and insurance. *Proceedings of the Aristotelian Society* 2004;78:131-150.

[19] For further discussion on the moral (ir)relevance of the distinctions made in this discussion, see, for example, Lippert-Rasmussen, K. Are Some Inequalities more Unequal than Others? Nature, Nurture and Equality. *Utilitas* 2004;16:193-219; Nagel, T. Justice and nature. *Oxford Journal of Legal Studies* 1997;17:303-321; Braveman, P & Gruskin, S. Defining equity in health. *Journal of Epidemiology and Community Health* 2003;57:254-258.

choices. However, some of the more recent contributions to the debate have proposed a more nuanced interpretation of the luck egalitarian approach. This section sets out the implications of the luck egalitarian approach for individual responsibility as a rationing criterion in light of this literature.

Importantly, the basic luck egalitarian proposal is no more than a framework, according to which responsibility is crucial in distinguishing fair from unfair inequalities. Depending on how the details of this framework are fleshed out, in particular with respect to the notion of responsibility we adopt, very different interpretations of the basic theory can emerge. The early work on luck egalitarianism focused on setting out the basic framework of the approach and generally did not spell out the conditions under which people could reasonably be held responsible for inequalities resulting from their choices, even though this is, of course, a crucial issue if we are to consider the policy implications of luck egalitarianism.

Critics have argued that luck egalitarianism is too harsh in responding to inequalities that can be traced back to individuals' choices or actions. Health needs have featured prominently in the examples that critics of luck egalitarianism have used to illustrate this problematic implication of a responsibility-sensitive approach: luck egalitarians, these critics argue, are committed to denying treatment to individuals who, through their own choices, brought about particular needs, including needs for health care.[20] For example, a negligent driver must be left to die if he is responsible for the accident in which he is involved. While examples such as these are commonly presented as

[20] E.g. Anderson, E. What is the point of equality? *Ethics* 1999;109:287-337, Fleurbaey, M. Equal opportunity or equal social outcome. *Economics and Philosophy* 1995;11:25-55.

challenges to luck egalitarianism,[21] theorists who are sympathetic to the luck egalitarian approach have similarly implied that luck egalitarians may have to deny care to people whose choices have brought about a certain health need.[22]

It is partly in response to these criticisms that the recent literature on luck egalitarianism has paid far more attention to the potential harshness of the luck egalitarian approach, attempting to clarify the luck egalitarian position on examples such as these. Perhaps the most significant problem these theorists see with the 'harshness objection' is that the critics falsely assume that the 'choice' component of the chance-choice distinction on which luck egalitarians rely must map neatly onto the actual choices people make in the real world. In fact, the real-word implications of the luck egalitarian approach are far from clear.[23] Importantly, luck egalitarians are not committed to taking the mere presence of choice as sufficient to justify the inequalities that may result from it; they can rely on different interpretations of the notion of individual responsibility to flesh out the distinction between 'chance' and 'choice' and to determine under what conditions individuals can reasonably be held responsible for the choices they make.[24] In particular, three aspects of the recent literature are relevant.

First, in fleshing out the distinction between option luck and brute luck, which is to guide the luck egalitarian in deciding whether specific inequalities are fair or not, some

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[21] E.g. Anderson, 1999, op. cit.
[22] Cappelen, AW & Norheim, OF. Responsibility in health care: a liberal egalitarian approach. *Journal of Medical Ethics* 2005;31:476-480, Cappelen, AW & Norheim, OF. Responsibility, fairness and rationing in health care. *Health Policy* 2006;76:312-319.
[23] Cohen, GA. 2008. *Rescuing Justice and Equality*. Cambridge, Mass.: Harvard University Press, Cohen, 1989, op. cit..
[24] Arneson, RJ. Egalitarianism and the undeserving poor. *Journal of Political Philosophy* 1997;5:327-350, Barry, N. Reassessing luck egalitarianism. *Journal of Politics* 2008;70:136-150.

theorists have relied on the idea of 'reasonable avoidability'.[25] This means that simple mistakes as well as infinitesimal risks that we all need to take in leading our lives need not be regarded as option luck.[26] Further, as Arneson explains in spelling out the requirements of his interpretation of equality, it would be unfair to expect as much from a person who is extremely averse to labour as from someone who enjoys hard work:

> The more difficult and painful it is for an individual to make a best choice, the less reasonable it is to expect that she will make that choice. In other words, people have equal opportunity for welfare when the cards they are dealt are such that if they play their cards as well as one could expect, they gain the same expected welfare, and if they play worse than this, their less than best options are matched in expected welfare.[27]

The ability to make reasonable and prudent use of one's talents is itself an ability that is distributed unequally across persons; the welfare inequalities to which such inequalities in this ability may lead are, therefore, likely to be unfair. Arguably, inequalities of this kind affect individuals' health behaviours. For example, many of us, to greater or lesser extent, find it difficult to engage in 'healthy' behaviours or refrain from unhealthy ones due to weakness of will or because we are insufficiently sensitive to the long-term risks associated with particular choices.

Second, many commentators have emphasised that, for luck egalitarians, the influence of external background factors on the choices that people make may undermine their responsibility for those choices: when individuals face highly unequal circumstances in which they make their decisions, making it very easy for some to avoid specific risks but exceedingly difficult for others, it becomes highly implausible that such choices

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[25] E.g. Arneson, 1997, op. cit, Segall, 2009, op. cit..
[26] [omitted for review]
[27] Arneson, R. Equality of opportunity for welfare defended and recanted. *Journal of Political Philosophy* 1999;7:488-497: 488-489.

would be sufficient to ground individuals' responsibility for them.[28] This interpretation of the luck egalitarian approach has particular bearing for the health context, where there has been increasing attention to social inequalities in health outcomes. Some of these inequalities appear to be the result of environmental differences, such as housing inequalities or unequal working conditions, which often accumulate over the life course. However, some of these inequalities are the result of differences in health behaviours, such as smoking rates, nutrition or physical activity.[29] A version of luck egalitarianism that is sensitive to the influences of background conditions on the choices people make can help us account for the intuition that these health inequalities are problematic, even when they can be traced back to the choices individuals have – often voluntarily – made.[30]

Third, some of the choices individuals make contribute to the fulfilment of shared social duties. Where some fulfil a greater share of such collective duties than others and suffer disadvantages as a result, luck egalitarians need not require that these are borne by the individual concerned.[31] This concern can become relevant to the health context when such duties – for example, duties to care for children or the elderly – detract from individuals' ability to look after their own health.

These recent developments in the luck egalitarian literature suggest that proponents of the theory can take a more nuanced position than their critics have often assumed on

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[28] Barry, N. Defending luck egalitarianism. *Journal of Applied Philosophy* 2006;23:89-107, Barry, 2008, op. cit..
[29] Marmot, MG & Wilkinson, RG. 2006. *Social Determinants of Health*. 2nd edn. Oxford: Oxford University Press.
[30] [omitted for review]
[31] Stemplowska, Z. Making justice sensitive to responsibility. *Political Studies* 2009;57:237-259.

whether or not individuals should be held responsible for health needs that are the result of their own choices. Since many real-world choices reflect brute luck, the policy implications of luck egalitarianism appear closer to traditional egalitarian positions than much of the literature has assumed. Rather than denying care to those whose choices have contributed to their health needs, luck egalitarians suggest that we need to pay close attention to the factors that make some more likely than others to make choices that involve risks to their health.

4. HEALTH PROMOTION AND INDIVIDUAL CHOICE: INCENTIVISING INDIVIDUALS TO 'TAKE RESPONSIBILITY' FOR THEIR HEALTH

We can also find appeals to individual responsibility that are tied to the provision of positive or negative incentives in an attempt to encourage individuals to 'take responsibility' for their health. Many theorists, including those who are very critical of using individual responsibility in rationing decisions, have been supportive of such policies, citing the significant contribution incentives could make to improvement of individual health outcomes. Moreover, it has been argued that luck egalitarianism, to its own detriment, does not have the theoretical resources to support policies of this kind. In this section, I argue that incentive policies are structurally similar to the use of responsibility as a rationing criterion; we should therefore not be too quick in welcoming these policies. Many of the concerns that have been raised about responsibility as a rationing decision apply to incentives as well. I also clarify the position that luck egalitarians will take on this issue.

So-called 'positive' incentives that aim to encourage individuals in adopting beneficial health behaviours have become a popular policy tool in many countries. For example, German sickness funds offer enrolees benefits ranging from kitchen scales and crockery sets to children's toys and MP3-players if they meet conditions such as participation in cancer screening programmes or check-ups.[32] In the US, employers can offer premium discounts or lower deductibles for employees who participate in weight loss or smoking cessation classes, or meet certain goals with respect to their weight or blood glucose levels.[33]

The arguments for the use of incentives often draw on the idea of responsibility for health, both in describing how incentives work and in justifying their introduction. Incentives, on this argument, encourage individuals to take responsibility for their health and to make 'more responsible' choices with respect to health behaviours, such as smoking or diet.[34]

It is important to note that the structural similarities between incentive schemes and the use of individual responsibility as a rationing criterion make it difficult to draw a clear distinction between them. In the literature, distinctions between 'retrospective' or 'backward-looking' notions of responsibility on the one hand, and 'prospective',

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[32] Schmidt, H, Gerber, A & Stock, S. What can we learn from German health incentive schemes? *British Medical Journal* 2009;339:725-728.
[33] Schmidt, H, Voigt, K & Wikler, D. Carrots, sticks, and health care reform — problems with wellness incentives. *New England Journal of Medicine* 2010;362:e3(1)-e3(3).
[34] E.g. Florida Agency for Health Care Administration, Florida Medicaid Reform Application for 1115 Research Demonstration and Waiver, October 2005, http://ahca.myflorida.com/medicaid/medicaid_reform/waiver/pdfs/medicaid_reform_waiver_final_101905.pdf.

'forward-looking' interpretations of the concept on the other,[35] are often drawn, along with the suggestion that, even we think that retrospective applications of responsibility are problematic, forward-looking ones may not be.[36] However, where 'prospective responsibility' is linked to incentives, it is difficult to see how these two notions of responsibility could be kept distinct. Attempting to encourage individuals to change their behaviour by using an incentive implies that, if the desired behaviour change does not occur, individuals will not be eligible for the incentive.[37] Thus, even if policy-makers promote incentives out of a genuine desire to encourage and support individuals in adopting beneficial health behaviours, the structure of incentive schemes is very similar to policies that deny benefits to those whose ill health is the result of behaviours for which they are deemed responsible.

These problems notwithstanding, incentives may be a useful instrument for the improvement of population health. However, it has been argued, luck egalitarians may lack the theoretical resources to endorse the use of instruments that improve population health. Daniels has pointed to some problems with luck egalitarian arguments when it comes to the improvement of health through schemes that aim to improve individuals'

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[35] For the distinction between prospective and retrospective responsibility, see, for example, Marckmann, G. 2005. Eigenverantwortung als Rechtfertigungsgrund für ungleiche Leistungsansprüche in der Gesundheitsversorgung? In *Gleichheit und Gerechtigkeit in der modernen Medizin.* O. Rauprich, et al., eds. Paderborn: Mentis: 300-313, Marckmann, G, Möhrle, M & Blum, A. Gesundheitliche Eigenverantwortung. *Der Hautarzt* 2004;55:715-720. The distinction between backward and forward-looking notions of responsibility is used by Feiring, E. Lifestyle, responsibility and justice. *Journal of Medical Ethics* 2008;34:33-36, Kelley, M. Limits on patient responsibility. *Journal of Medicine and Philosophy* 2005;30:189-206.

[36] E.g. Feiring, 2008, op. cit.

[37] On this, see also Wikler, D. Persuasion and coercion for health: ethical issues in government efforts to change life-styles. *Milbank Memorial Fund Quarterly* 1978;56:303-327: 300.

behaviours.[38] Luck egalitarians, he argues, do not have the resources to argue for schemes that would prevent health inequalities which – because they result from individuals' choices – would be fair: 'As a matter of justice we do not owe people assistance for what they bring on themselves as a result of their choices of imprudent behaviour, so we do not owe them any effort at making them act more prudently.'[39] Thus, despite luck egalitarians' focus on individual responsibility, their theory implies that 'there is no reason for promoting [responsibility] as a matter of justice'.[40] Thus, 'I find no support for Florida's experiment [which used incentives to encourage healthier behaviour in Medicaid recipient] in the luck egalitarian framework, and this is a problem for the framework'.[41] In other words: to the extent that attempts at health promotion merely prevent health inequalities that would, because of their link to individual choices, be considered fair within the luck egalitarian framework, luck egalitarians do not have an argument to support health promotion.

Daniels is right that luck egalitarians are indifferent between distributions that are equal and distributions that contain only fair inequalities; luck egalitarianism does not provide an argument for the prevention of *fair* inequalities. This may well point to a problematic feature of luck egalitarianism. However, we must be clear that, depending on our understanding of the choices that underpin health behaviours and the degree to which individuals can reasonably be held responsible for such choices, the scope of Daniels' argument may be limited. Given the social inequalities that shape and constrain

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[38] Daniels, N. 2011. Individual and social responsibility for health. In *Responsibility and Distributive Justice*. C. Knight & Z. Stemplowska, eds. Oxford: Oxford University Press: 266-286.
[39] Daniels, 2011, op. cit., 285.
[40] Daniels, 2011, op. cit., 285.
[41] Daniels, 2011, op. cit., 285.

individuals' 'lifestyle choices', luck egalitarians may find few health inequalities in the real world that they would consider fair. Preventing *unfair* health inequalities is, of course, of utmost importance for luck egalitarians; the problem Daniels highlights may therefore not apply to the context in which he considers it.

With respect to real-world incentive schemes, luck egalitarians' concerns about the unfair inequalities to which incentives may give rise broadly fall into two groups. First, access to incentives may not be equal; second, unequal uptake of incentives may exacerbate social inequalities in health.[42] Luck egalitarians may be more supportive of incentive schemes that actively try to address the barriers that unfairly disadvantaged individuals face in adopting beneficial behaviours, for example when low-income patients receive a financial incentive for attending a screening appointment, which allows them to defray some of the costs they face in attending. Note, however, that in such cases, incentives effectively act as compensation for existing inequalities. We would then need additional arguments as to why it is legitimate to make such compensation conditional on individuals' meeting particular requirements, rather than simply providing it unconditionally.

5. FAIR RECIPROCITY AND RESPONSIBILITY FOR HEALTH

A number of recent policy documents have also appealed to citizens to be 'responsible' with their health and with respect to their use of health care resources, without recommending the use of incentives or penalties for those who fail to act in the proposed ways. For example, the NHS constitution emphasises the 'rights and

[42] [omitted for review]

responsibilities' of both staff and patients.[43] Addressing patients, this includes, foremost, that '[y]ou should recognise that you can make a significant contribution to your own, and your family's, good health and well-being, and take some personal responsibility for it'.[44] In the theoretical literature, some proposals have tied the idea of individual responsibility to the notion of reciprocity. For example, Buyx suggests that, in solidaristic health care systems, reciprocity may require that individuals contribute to the health care system and behave responsibly within in, for example by avoiding certain health risks or by taking care in their use of health care resources.[45] Similarly, Feiring argues that, given scarcity of resources, appeals to individual responsibility, and giving lower priority to patients who act in ways that make treating them less effective than it could be, may be appropriate because 'we owe it to each other to do what we can to make medical treatment efficacious'.[46] Thus, she argues, obese patients may be asked to commit to making behaviour changes that will help them lose weight; if they refuse, it is permissible to give them lower priority vis-à-vis other patients.[47]

The idea, then, is that health care systems work on the basis of a principle of reciprocity: individuals can expect to receive treatment for their health needs but, in return, all those contributing to the system can expect its beneficiaries to act responsibly

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[43] Department of Health. 2009. *The handbook to the NHS constitution.* Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093415.pdf [Accessed 1 September 2009].

[44] NHS, The NHS Constitution: The NHS belongs to us all. Interactive version, http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/nhs-constitution-interactive-version-march-2010.pdf.

[45] Buyx, A. Personal responsibility for health as a rationing criterion: why we don't like it and why maybe we should. *Journal of Medical Ethics* 2008;34:871-874.

[46] Feiring, 2008, op. cit., 35.

[47] A similar argument is provided by Glannon, who suggests that we have a moral responsibility not to heighten the scarcity of organs available for transplant, and that this implies that we should give lower priority to alcoholics when it comes to liver transplants; Glannon, W. Responsibility and priority in liver transplantation. *Cambridge Quarterly of Healthcare Ethics* 2009;18:23-35.

within it, by avoiding unnecessary health risks or making sure that they do what they can so that any treatment they receive is effective. For example, the NHS Constitution emphasises that '[t]he NHS belongs to all of us. There are things that we can all do for ourselves and one another to help it work effectively, and to ensure resources are used responsibly'.[48] This approach does not necessarily entail sanctions for those who fail to meet the stipulated requirements of reciprocity (no sanctions are envisioned by in the NHS constitution, for example) but Buyx and Feiring suggest that it may.

The idea of reciprocity can, of course, be fleshed out in very different ways. What exactly reciprocity is taken to require depends on what notion of distributive justice we adopt.[49] In the literature on reciprocity in the context of welfare requirements, egalitarian theorists have pointed out that reciprocity need not require everyone to make contributions of equal value; rather, on an egalitarian understanding of reciprocity, the contributions we can expect from any one individual may vary depending on their ability to contribute.

How might a luck egalitarian flesh out the idea that everyone should 'do their bit'? First, as White emphasises, differences in individuals' ability to contribute to a cooperative scheme may be due to brute luck; such differences should not affect what individuals can expect to get out of the scheme.[50] Furthermore, the reasonable expectations standard mentioned in section 3 above will also come into play here. When

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[48] NHS, The NHS Constitution: The NHS belongs to us all. Interactive version, http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/nhs-constitution-interactive-version-march-2010.pdf..

[49] Segall, S. Unconditional welfare benefits and the principle of reciprocity. *Politics, Philosophy & Economics* 2005;4:331-354, White, S. Liberal equality, exploitation, and the case for an unconditional basic income. *Political Studies* 1997;45:312-326.

[50] White, 1997, op. cit.

considering what individuals should be required to contribute to the scheme, we must adapt our expectations in light of what they can reasonably be expected to contribute. The inequalities that characterise the real-world context in which such arguments are made are again highly relevant here. For example, some may have very flexible work conditions that make it easy to attend medical appointments during the working day at little notice; for others, any absences would lead to lower pay. In such circumstances, applying a uniform standard of expectations when it comes to patients' attendance of medical appointments would be unfair.

It might be argued that this concern is not relevant when, as is the case in the NHS constitution, no sanctions are attached to people's failure to meet the stated expectations of reciprocity. However, the reciprocity approach implies that those who do not live up to required standards are regarded as free-riders on the cooperative scheme. Thus, to apply the same expectations to everyone, regardless of brute luck differences among individuals in their ability to meet such expectations is not consistent with an egalitarian understanding of fair reciprocity, even when no negative sanctions are involved.

6. THE LANGUAGE OF INDIVIDUAL RESPONSIBILITY AND ITS CONSEQUENCES

The previous sections discussed different ways in which the notion of individual responsibility has been used in debates about health resource allocation and discussed the luck egalitarian position on these different ways of appealing to individual responsibility. This section raises a more general concern about the language of responsibility and its possible effects on individuals' well-being and, ultimately, health,

that may result from the increasing prominence of this language in policy debates. Such effects also raise concerns about the application of luck egalitarianism to the real world that have received relatively less attention in the literature.

A frequently cited aim of the luck egalitarian approach has been to 'incorporate[e] within [egalitarianism] the most powerful idea in the arsenal of the anti-egalitarian right: the idea of choice and responsibility'.[51] Accordingly, many luck egalitarians have tried to formulate a nuanced understanding of individual responsibility in drawing the distinction between fair and unfair inequalities. This understanding of responsibility, however, is at odds with how responsibility tends to be conceived in public debate. There, appeals to individual responsibility are generally understood in more conservative terms, emphasising the importance of individual choice while understating the relevance of social structures that may constrain such choices. It is not clear that luck egalitarians, in formulating arguments about individual responsibility and fairness, can keep their notion of responsibility distinct from the one that dominates policy debates.[52]

This is an important problem because the values and assumptions implicit in policy debates may in themselves have significant impact on individuals. On the one hand, it has been suggested that emphasising the importance of individual behaviour could help address feelings of resignation and fatalism that are common particularly among

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[51] Cohen, 1989, op. cit., 933.

[52] This concern is also noted by Scheffler. He emphasises that conservatives use a simplistic, moralised discourse of individual responsibility that shifts the task of alleviating poverty to the poor. In its attempt to counter the conservative's use of individual responsibility, luck egalitarians may fall prey to a similar moralism; Scheffler, S. Choice, circumstance, and the value of equality. *Politics, Philosophy & Economics* 2005;4:5-28.

disadvantaged groups, helping individuals realise that, despite the structural constraints they face, there is scope for individual actions that can improve health.[53] This could enhance individuals' well-being directly and also improve their health behaviours, thus leading to improvements in health outcomes.

On the other hand, because appeals to individual responsibility cannot easily acknowledge individuals' unequal ability to adopt healthy behaviours, they risk trivialising the structural constraints that individuals, especially those from disadvantaged backgrounds, face. This could contribute to a sense of personal failure when health behaviours cannot be adopted or maintained, and may lead to feelings of guilt, shame, frustration or self-blame.[54] One empirical study finds self-blame in narratives of patients with health conditions linked to certain behaviours, and the emphasis on self-blame was more pronounced in those living in deprived areas.[55] Importantly, these feelings may also become an obstacle to the improvement of health behaviours[56] and may deter patients from seeking treatment or support.[57]

Furthermore, an emphasis in public debates on individual responsibility rather than the wider social determinants of health may contribute to the stigmatisation of those who

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[53] Schmidt, H. Personal responsibility in the NHS Constitution and the social determinants of health approach: competitive or complementary? *Health Economics, Policy and Law* 2009;4:129-138.
[54] Guttman, N & Salmon, CT. Guilt, fear, stigma and knowledge gaps: ethical issues in public health communication interventions. *Bioethics* 2004;18:531-552, Guttman, N & Ressler, W. On being responsible: ethical issues in appeals to personal responsibility in health campaigns. *Journal of Health Communication* 2001;6:117-136.
[55] Richards, H, Reid, M & Watt, G. Victim blaming revisited: a qualitative study of beliefs about illness causation and responses to chest pain. *Family Practice* 2003;20:711-716.
[56] Guttman & Ressler, 2001, op. cit., 121.
[57] Richards, et al., 2003, op. cit.

act 'irresponsibly' by failing to adopt behaviours regarded as healthy.[58] Empirical studies lend support to some of these concerns. For example, a study by Chapple et al. reports that lung cancer patients feel stigmatised due to the close link between smoking and lung cancer, even if they themselves never smoked.[59]

How exactly the language of individual responsibility affects individual well-being and behaviours is, of course, an empirical question. However, in moving from theory to practice, one of the considerations luck egalitarians must take into account is the effects of the language in which their arguments are couched. If that language has problematic consequences, particularly by contributing to unfair inequalities, this will necessitate greater care in attempts to apply luck egalitarianism to the real world. This, of course, is part of a more general concern that luck egalitarians need to think very carefully about how their theory can or should be implemented, as its practical implementation 'can harm the very people that the theory is designed to help'.[60]

7. CONCLUSION

Appeals to individual responsibility have become common in philosophical discussions about the fair distribution of health care resources as well as policy documents and public debate. The paper distinguished between three different kinds of appeals: those that use individual responsibility as a rationing criterion, those that involve the promotion of incentives to encourage healthier behaviours, and those that tie individual

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[58] Popay, J. Should disadvantaged people be paid to take care of their health? No. *British Medical Journal* 2008;337:a594.
[59] Chapple, A, Ziebland, S & McPherson, A. Stigma, shame, and blame experienced by patients with lung cancer: qualitative study. British Medical Journal 2004;328 doi:10.1136/bmj.38111.639734.7C.
[60] Wolff, J. Fairness, Respect and the Egalitarian Ethos Revisited. *Journal of Ethics* 2010;14:335-350.

responsibility to a notion of fair reciprocity. One aim of the paper was to consider these arguments in light of recent developments in the literature around luck egalitarianism. While the luck egalitarian approach is often taken to require that individuals be denied assistance with their health needs if those needs are the result of their own choices, the recent literature emphasises a more nuanced interpretation of the luck egalitarian approach. Further, luck egalitarianism can provide insights into why the other two kinds of appeals to responsibility are problematic from the perspective of equality. The use of incentives raises concerns about equality, particularly with respect to concerns about unequal access, while the reciprocity-based account must be careful to spell out which duties can be imposed on individuals given important differences in what they can reasonably be expected to contribute. The discussion also raised concerns about the language of individual responsibility itself, which may have negative effects on individuals that run counter to (luck) egalitarians' intentions.

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