PART III

RESPONSIBILITY FOR HEALTH AND HEALTH CARE

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Personal and Social Responsibility for Health

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6.1. INTRODUCTION

In many cases, illness is not something that just happens to a person. We are more likely to remain healthy if we take care of ourselves. People who live prudently tend to live longer and to avoid disability. The best hope for many people who are seeking to maintain or improve health is to adopt healthier lifestyles.

These facts suggest a division of labour in the pursuit of health. In addition to maintaining a health system for prevention and therapy, society can try to create a healthy social and physical environment, and can also provide information on risk factors. For their part, individuals can use this information, along with their own knowledge and common sense, to maintain their health as best they can to reduce the need for care.

In the ordinary public health perspective, avoiding diseases and disabilities that stem from personal choices is no less important as a goal than the avoidance of any other maladies. They may require different strategies for prevention, management, or cure, and the individual's liberties must be respected. Otherwise, however, a health need is a health need, equally deserving of concern and attention.

But this is not the only perspective from which to view the potential contribution of individual behaviour to health. Some would wish to respond differently to health needs depending on who is responsible for creating and maintaining them. In this view, what we can do for ourselves, we should not look to others to do for us. If we become sick or disabled as a result of neglecting to take care of ourselves, or by having taken undue risks, then dealing with these health needs should be seen as personal rather than social responsibilities and as such should not be considered on a par with other, unavoidable health needs.

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The theme of personal responsibility has increased in prominence in health policy during the last twenty-five years. Initially, its principal use was to argue for policies that took account of externalities: burdens imposed on others when individuals gambled with health. These were debates over the financing and operation of the personal health care system. The solutions offered to the problem required that those who took risks with health assumed more of the burdens of the consequences: they might receive lower priority for treatment, or be made to pay fees for supplementary insurance. More recently, however, it has begun to figure in debates in public and international health. For example, it has been argued that any response in public health policy to the correlations between socio-economic status and health that have received much attention in recent years must take into account the degree to which the differences in health between social classes is due to differences in how well people in different strata take care of themselves. To the extent that class differences in health and longevity simply reflect how well or how badly people in different circumstances protect their health, in this view, these correlations are not a social responsibility and hence should not have priority over other health concerns.

More broadly still, the concept of personal responsibility for health has figured in efforts to delimit the sphere of public health, both national and international. In this view, public health should not address itself to 'risk factors' without first determining whether these risks are voluntarily assumed. If people know what risks they are taking, but accept them as the price of pursuing goals that they hold in higher priority, then it is not the business of public health to re-order these priorities and insist that the risk factors be avoided so that health is valued above all. For example, international efforts to curb the use of tobacco has been criticised on the grounds that the gamble one takes in smoking is a personal matter, and that scarce resources should be directed toward involuntary risks, focusing on those infectious diseases that afflict populations regardless of personal initiative.

Though it has been mentioned in these varied contexts, the claim that personal responsibility for health should be taken into account in health and public health policy is not one that has figured prominently in current debates. In my view, it is worth a more careful examination than its peripheral role in public health policy to date might indicate. This is not because this theme should figure more prominently in public health, for I argue that it deserves its place on the periphery. But to do this we must first acknowledge that the notion of personal responsibility for health may have considerable appeal. It seems to comport with basic intuitions about fairness, and also with a prominent strain in contemporary work in the theory of justice. Its implications for public health policy are striking and extensive. If, as I believe, the moral claims about personal responsibility for health should make at most a minor appearance in our public health debates, it is worth taking careful aim at arguments to the contrary and thereby to disarm potential opposition to what I believe are important and justifiable public health interventions.

In what follows, I will briefly describe the uses to which notions of personal responsibility have been put in health policy debates. To stay focused, but at some cost to clarity, I will rely on context to fix the sense of 'responsible' that figures in these debates. In Section 6.3, I connect these uses of the notion of personal responsibility for health to recent work in the theory of justice. The last section of the chapter attempts to point out some limitations on these arguments. I conclude that though individuals should be encouraged and enabled to remain healthy through informed and prudent habits of living, the misery that results from illness and injury should remain a burden that is shared.

6.2. THE POTENTIAL SIGNIFICANCE OF PERSONAL RESPONSIBILITY FOR HEALTH

Though concern for the individual's role in maintaining health is not at all new—such themes can be found in Galen (AD 180) and in other ancient medical traditions (Reiser 1985)—its prominence has increased in the wake of the epidemiological transition. With infectious diseases giving way in wealthier countries to non-communicable diseases as leading causes of illness and premature death, the scope for state intervention in reducing the transmission of infectious agents has declined in importance. For many of these maladies, the most effective actor is the individual, not the state, and thus the way a person lives—one's 'life-style'—becomes the key to improvement in health. Emphasis on lifestyle in health policy was fuelled in the 1960s by the accumulation of evidence of the health effects of smoking and other behavioural risk factors. Not long afterward, a flurry of governmental white papers led to announcements that national health strategies would be retargeted. An emphasis on behavioural change would, according to the new policies of Canada (Lalonde 1974), the United Kingdom (DHSS 1976), and the United States (Surgeon General 1979), broaden the scope of national health policies beyond traditional medical and surgical interventions. The role of behaviour as a key to health was not limited to non-communicable disease, for within a decade some of the same strategies seemed to offer the most effective front-line defence against AIDS.

Though the governmental reports and proposals generally steered clear of moral judgements about those who would not take proper care of themselves, a few individuals did not. The most widely noted was John Knowles, then president of the Rockefeller Foundation, who wrote that 'one man's freedom in health is another man's shackle in taxes and insurance premiums', and urged that 'the idea of a "right" to health should be replaced by the idea of an individual moral obligation to preserve one's own health—a public duty if you will'. (Knowles 1977).

Knowles offered this observation as an argument in favour of prudent self-management, but offered little elaboration. A small literature that accumulated

in the ensuing years, some supporting Knowles, others opposed, brought out some of its implications (Wikler 1978, 1985, 1987; Veatch 1980; Dworkin 1981; Leichter 1991; Wikler and Beauchamp 1995). A health policy that would take Knowles's proposal seriously would include several elements: prohibitions and other curbs on risk taking, lower priority for treatment in case of injury or illness and compulsory insurance payments, either as such or in the form of excise taxes.

The first way to ensure that people do not burden others with the costs of care stemming from imprudence is to enforce rules requiring healthy choices, such as requirements that drivers wear seatbelts and that motorcyclists use safety helmets. In such cases it may be difficult to separate out the motive of protecting others from avoidable costs from paternalist concern to protect the individual against his or her own reckless impulses. These goals offer separate and potentially reinforcing support for protective measures. Insofar as the weight of the law is used to ensure that individuals make healthy choices, however, it may not be right to say that these measures support the idea of personal responsibility.

The second element of health policy assigning responsibility for health to the individual would be the prospect that treatment for avoidable illness and injury would have lower priority, or perhaps would be left untreated, at least at public expense. Transplant surgeons, for example, conducted a long debate over whether alcoholics should have the same priority as others when needing new livers. Much of this discussion turned on medical suitability rather than any moral (or moralistic) notions, and the trend has been to accept alcoholics on a par with others (Starzl et al. 1988; Schenker et al. 1990; Knechtle et al. 1992). But the fact that this class of patients would be singled out on the basis of their (possibly) poor prognosis might also betray a sense that their role in ruining their livers weakened their claims. Similar conclusions might hold concerning a debate within the NHS over provision of *in vitro* fertilization to women who smoke (Sylvester 1999). While the head of the Royal College of Obstetricians and Gynaecologists formulated its principle as 'you do your bit and we will treat you'—a moral principle of reciprocity—the evidence given in support of its position referred to the lower probability of conception among smokers. Other manifestations in this vein which have been booted around occasionally in health policy debates include proposals to eliminate dentures from national health plans (on the ground that people who took proper care of their teeth throughout their lives would not need them) and arguments against long-term care for the aged (both because people should make arrangements with family or others to care for them in time of need and also because people who keep fit are less likely to need extended long-term care). A variation on this theme would involve withholding an expensive medical intervention unless and until the patient had tried first to achieve health through lifestyle modification, such as reduction of dietary salt intake versus anti-hypertension drugs.

A third way of assigning personal responsibility for health, or for the costs of treatment, would be to insist that the potential risk taker pay in advance for insurance against added risk, either in the form of a user fee or a specific tax. One example is the user fee for dangerous sports, intended to cover the added costs of paying for care in case of accident. The high cost of evacuation and treatment of alpinists injured on Mt. Ranier, near Seattle, prompted calls for higher fees for permits. Again, the motivation behind such steps may be complex. The principal motive for cigarette taxes, for example, may be to add to state revenue, or it may be paternalist. If the goal is to assign responsibility for costs to the individual, the appropriate taxation level is difficult to estimate, not only because smokers incur certain costs but may avoid others by dying early, and because smokers who die prematurely may forfeit productivity but, since the lethal effects of tobacco use are not immediate, society may be spared the cost of their pensions.

This brief account suggests that some measures enacted in the United States and the United Kingdom may be viewed as placing responsibility for health on the individual. At the same time, present-day health policy does not go nearly as far as it could, were it to embrace this doctrine without reservation. With a few exceptions, such as drinkers and smokers seeking liver transplants and assistance in reproduction, respectively, patients are treated according to their need regardless of their responsibility in creating the need. Though encouragement of healthier lifestyles has become a priority of the Department of Health and Human Services in the United States in recent years, we remain free to overeat, under-exercise, and smoke without paying penalties beyond the resulting illnesses themselves. And though taxes and other prepay mechanisms to cover the resulting health costs are not unknown, their use is inconsistent. Using existing policies as evidence, policy-makers can be understood to reject the assignment of responsibility for health at least as often as they rely on it.

6.2.1. *Personal responsibility and inequalities in health*

The correlation of health and longevity with social position—occupational and social status, educational level, and other indices of hierarchy—has been recognised for many decades, at least by social scientists. In recent years, this relation of health to socio-economic stratification has moved to the centre of public health concerns (Wilkinson 1996; Auerbach and Krimgold 2001). Up and down the socio-economic ladder, the better-off one is economically and socially, the better one's health and the longer one's life (Marmot et al. 1991, 1997; Evans et al. 1994; Wilkinson 1996). Death rates from 80 per cent of the eighty most common causes of death are higher for blue-collar workers than for white-collar workers (Wilkinson 1996); the differences in many cases are several-fold. Inequalities among social groups, also including racial groups, are as great in the United States and some other wealthy countries as the differences

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between wealthy countries and much poorer ones. As international evidence continues to accumulate documenting the relationship between socio-economic status and health,' Marmot et al. (1997) have written, 'a good case can be made that this is the major unsolved public health problem of the industrialized world'.

What do these findings suggest for health policy? On the assumption that those on the low end of the inequalities are biologically similar to those who are favoured, they seem to indicate that much opportunity for improved health exists for large segments of the population. If we know why the wealthy and healthy are doing so well, perhaps we can bring others up to their level.

This observation does not in itself entail that we *should* do so. That depends, in part, on the costs involved in efforts to narrow health inequalities, which might involve anything from paying for targeted health promotion to interference in labour markets to redistributing society's wealth and markers of status. But the implications for health policy (and social policy generally, given that the interventions required may lie outside of the domain of health care and public health) are not fully contained within a calculation of their costs and potential benefits. We also need a moral account, a compelling argument that health inequalities represent or constitute an injustice that places a claim on society's resources. Unless the inequalities associated with social position are unjust, interventions aimed at narrowing them would have to compete with other public health measures on the basis of ordinary standards used in setting priorities. If they are required to remedy an injustice, however, they might take higher priority, and might even be worth undertaking greater expenditure with lesser results.

What is the nature of this alleged injustice? For the most part, the public health literature has been concerned to document and to explain these group and individual variations. Perhaps the unfairness of adding illness and premature death to inferior social status seems obvious. These issues have only begun to attract attention from philosophers, but the few studies published to date (Marchand and Wikler 1998; Daniels et al. 2000) have located considerable complexity in the argumentation needed to establish this conclusion. For example, it is not clear that the injustice lies in the inequality per se or in society's failure to do more for those on the low end (regardless of the effect of such measures on inequality, for example, if the better off simultaneously benefit).

Also at issue is whether the differences in health status discovered in this research should be regarded as unjust only if they are the product of differences in social status which are themselves unjust. For example, one might argue that differences in health and longevity between racial or ethnic groups are unjust, and should be targeted by social policy, if they reflect racial or ethnic discrimination and stigma. Differences between racial groups not subjected to discrimination and stigma, or differences (however unlikely) in which stigmatised groups do better, would not count as injustices, on this view. Women's higher life expectancy might be such a case (Kekes 1997).

Similarly with class and other measures of social status: if the injustice of inequalities in health derives from the injustice (if any) of the social group differences which produce them, then we will regard differences in social position or class for health and longevity as unjust to the extent that we think that existing differences in control over work, income, occupational prestige, and other components of social position or class are themselves unjust. If high-status women have higher breast cancer rates because they postpone having children until they complete higher education, this class difference would not be unjust. And in a (mythical) society in which income varied only according to people's tastes for leisure versus labour (and its rewards)—a society in which income differences would be regarded as just by many people—any associated differences in health status might not be condemned as unjust, particularly if those who deliberated between leisure and labour were aware of these health consequences.

Alternatively, one might regard *any* group differences in health as unjust, perhaps unjust on their face, or else unjust in view of a comprehensive theory of justice that one accepts. For example, on the view that the norm of justice in the health 'sphere' of society is equality while in socio-economic competition there may be fair winners and losers, differences in socio-economic status might be deemed acceptable while the health inequalities they engender would be viewed as unjust (Walzer 1983).

On either view (though in varying circumstances), inequalities in health among social groups are likely to count as injustices, and hence to claim priority in the public health agenda. But the claim that inequalities in health represent injustices might be defeasible if the blame for the poorer health status of the less-favoured groups can be located in these individuals themselves. To those who claim that the inequalities between, say, racial groups, are an unjust product of unjust racism, those who stress personal responsibility may reply that racism would not have this consequence if members of the stigmatised group took better care of themselves. To those who find all social group differences in health objectionable, the response would be that people who differ in prudence should expect to differ in how healthy they remain. The locus of blame is key, for if blame is placed on the individual, social structure is exculpated, and the resulting suffering and premature death will not be counted as a social injustice. Narrowing health inequalities among social groups would thus not be of special urgency, either as a matter of prevention or of remedy.

The conclusion of the argument stressing personal responsibility need not be that public health should be unconcerned about the suffering of those on the low end of social group inequalities in health. Anyone who suffers illness and premature death deserves sympathy and, except for the most hard-hearted, some form of aid. But this is merely to say that their health needs will not receive priority among other health needs that might be targeted for public health action. It would require an additional step to maintain that locating blame for illness in the individual *reduces* the priority of giving them aid, relative to others who may suffer.

But this may be a step which some who stress personal responsibility would be logically impelled to take. The reasons supporting this extension of the argument point again to a locus of blame for illness. According to the lines of argument just presented, if social injustice (e.g. racism) is the source of an inequality in health, then, everything else being equal, those who suffer excess ill health due to their social position have a strong claim for remediation; and some will say also that inequalities in health which reflect even defensible differences in social status also deserve remediation. But more generally, most of us believe that health problems deserve social attention in their own right. In this most general case—the unremarkable and usual kinds of illness, injuries, and deaths—we may locate the 'blame' in nature, mediated by brute luck. The individual who becomes sick is simply in the wrong place at the wrong time, with the wrong kind of body with the wrong level of resistance to infection or injury. The individual becomes sick, or is injured, or dies, through no fault of her own, and our help is needed to combat the ills that nature has sent her way.

When the blame for a person's poor health can be placed on that person, it is no longer true that the blame rests in 'nature'; it is not a matter of brute luck, nor is this person sick through no fault of her own. From this perspective, the matter of personal responsibility for health does not merely lower the urgency of caring for an ill person (or preventing an illness that might befall a person) to that of ordinary medical distress, but lowers it still another rung on the ladder of moral importance. For some, it might negate the need for a social response altogether (though one would hope, in the name of decency, that an interpersonal response would still be forthcoming). In effect, this kind of thinking would remove whole tracts of the landscape of suffering from the health policy agenda.

The implications of this perspective for both domestic and international health policy are potentially vast. Roger Scruton (2000*a*,*b*), for example, has questioned the World Health Organization's effort to reduce smoking, one of the leading sources of disease and premature death worldwide, and a habit whose rapid spread in developing countries will kill many millions more in the next few decades unless effectively curbed. Scruton argues that smoking is 'in fact a voluntary activity and a source of pleasure, the risk of which entirely falls on the smoker'. Scruton does not extend the argument to AIDS, but it would seem to imply that governments should limit themselves to education on the risks of unsafe sex and needle sharing, rather than trying to curb these practices. And the same holds true for cardiovascular disease and the other main sources of reduced years of healthy life, insofar as they can be traced to choices, which are imprudent, so long as they are informed and voluntary. This way of thinking about public health might recommend measures under individual control, such as mosquito netting to guard against malaria, when they are alternatives to other disease reduction initiatives undertaken at public expense, such as eradication of mosquitoes, or even the treatment of malaria. Even more broadly, the same approach could distinguish patients who comply

with medical advice from the noncompliant, and those who seek prompt attention when they experience warning signs of disease from those who decide to wait and see if the condition develops.

The tabulation of health statistics, too, would be changed were this viewpoint to inform health policy. WHO, whose tobacco policy Scruton (2000*a*,*b*) challenges, computes smoking-related morbidity and mortality in its estimate of the global burden of disease. For Scruton, it is a 'semantic trick' to so classify smoking, 'on the spurious round that the methods used to measure its effect belong to the science of epidemiology'. A nation's progress in health, either in terms of average healthy life expectancy or in the distribution of this quantity, would be tabulated only in terms of unavoidable illness, that is, illness for which nature or society is to blame. Deaths and illnesses attributable to personal choices, not being the responsibility of society, would not figure in these target-setting tabulations. Or, if we wished health statistics to count all suffering and premature death regardless of cause, that which is attributed to individual voluntary choice could be ignored in calculations of the value of interventions and in charting the progress of countries in advancing public health.

Similarly, the assignment of responsibility for health impinges on the content of human rights, specifically on the right to health, Article 12 of the Covenant on Economic, Social, and Cultural Rights, which governments worldwide have ratified. If social and economic inequalities are as powerful in determining health expectancies as current research indicates they are, then signatories to the Covenant would seem to be obligated to narrow these inequalities, or to find ways to reduce their impact on health and longevity. But if we assign responsibility for the excess mortality and morbidity associated with socio-economic inequality to individuals, on the premise that these misfortunes stem from differences in lifestyles, reflecting different personal priorities, tastes, and character traits, then we cannot demand remedial action by states bound by the Covenant.

The views expressed in these last few paragraphs are rarely expressed as bluntly as Scruton has done. Perhaps many of those who attach the greatest importance to personal responsibility for health would disown them. Still, they still might be entailed by the premises of their view. These extensions and further implications are worth noting to the extent that they help us to understand the view better (and also perhaps because they offer the possibility of a *reductio ad absurdum*). Though one might deny that these implications follow (and I would agree that some additional assumption would be required), I believe that they indicate the need to examine the basis for stressing personal responsibility for health. Since this view has not been stated with precision in writing on inequalities in health and social determinants of health, I will attempt to furnish an argument, which rests on current theories of justice. If I can show that this argument does not secure its conclusions, I hope to have shown that no weaker argument could do so.

6.3. LUCK, EGALITARIANISM, AND PERSONAL RESPONSIBILITY IN RECENT POLITICAL PHILOSOPHY

In the previous section, I sketched some potentially far-reaching health policy implications which might be drawn from the everyday intuition that people who take risks should bear the burden if harm results. These began with the claim that those who take risks should be made to pay for the costs of their care, and went on to the view that they should lose their place in the queue when care must be rationed. A different kind of implication is that inequalities in health and longevity, including those which mirror unjust social inequalities and discrimination, represent no injustice if the immediate source of the health inequality is the imprudence of the less favoured.

While the first of these has appeared in writing on public health over the past quarter century, the second view has barely been articulated, perhaps because public awareness of the research on the correlation of health and the social structure has been limited. But criticism has been voiced by conservative commentators of public health scientists for putting the blame on social injustice rather than individual irresponsibility. 'Behind all their talk of racism and sexism', according to one recent critic (Mac Donald 1998, 2000), [their] 'real prey is individual responsibility . . . the public health revisionists are generating a remarkable body of excuses for the most avoidable and dangerous behaviours . . . ' An opinion piece in the *Wall Street Journal* editorial page attacked the claim that social injustice was the cause of excess morbidity among racial minorities, pointing instead to 'obesity, smoking, alcohol and drug use, reckless sexual behaviour' among other factors (Satel 1997). Similarly, the author, in her book-length critique of 'political correctness' in medicine, maintains that 'Social inequalities . . . do not literally produce the sedentary life-style, obesity, and risky behaviour that typically underlie many of the differences in health status between the less wealthy and the better-off' (Satel 2000: 30).

The exact dispute between these critics and their targets is not easy to pinpoint. They might disagree on how much of the difference in health status between social groups can be explained by differences in risk-taking behaviour. But the dispute might also centre on what to make of the contribution of behaviour to group differences, to the extent that it is an explanatory factor. The conservative critics see the answer lying not in remedies for social injustice, but in more prudent behaviour on the part of the poor—not only because this may be the more effective remedy, but because it places responsibility where (in their view) it belongs.

In so arguing, a left–right dispute entered the arena of public health that had been carried on in politics generally in the West for two decades. This controversy has engaged both popular politics and academic theorising. As Samuel Scheffler (1992, 1995) has noted, the conservative trend of the 1980s in politics in the

United States and United Kingdom traced in part to public dissatisfaction with the position taken by the left on the matter of personal responsibility. Scheffler links the stance toward personal responsibility taken by the political left (called liberals in the United States) with that of the academic political philosophy which also goes by that name. The welfare state is characterised by conservatives as offering a societal guarantee of at least minimal well-being regardless of an individual's prudence or effort, and faulted on that ground by politicians who led the right to victory in the Reagan and Thatcher years. For example, Newt Gingrich, a conservative in the US Congress, wrote that

> By blaming everything on 'society', contemporary liberals are really trying to escape the personal responsibility that comes with being an American. If 'society' is responsible for everything, then no one is personally responsible for anything. (Gingrich 1995)

Not that this in itself demonstrates any rejection by the public of philosophical liberalism. The public remains largely unaware of this academic literature; philosophical liberalism was not the inspiration for most political liberals (though some of the architects of the War on Poverty of the 1960s later claimed to have been inspired by Rawls); and political liberals, as the programme of the moderate left, differ on points of doctrine with Rawlsian and other philosophical liberals. What the two sorts of liberalism have in common, and what puts them in opposition to the popular mood of the era, according to Scheffler, is precisely the lack of significance that they attach to personal responsibility, and to the related moral notion of desert. On this ground, Scheffler concludes that the dominant school of political philosophy of these decades is wholly out of sync with the thinking of much of the public.

Though Scheffler did not address personal responsibility for health, there is empirical evidence that much of the public accepts the notion that people should do what they can to stay healthy, and that those who fail to do should be given lower priority in deciding whom to treat. For example, Edwards et al. (2003) asked a sample of Welsh adults which factors should be taken into account in determining position on priority lists for treatment. Forty-one per cent chose self-inflicted bad health, agreeing that 'A patient who has contributed to his/her own ill health, through for example smoking or driving dangerously, should wait longer than a patient who has not contributed to his/her own ill health.' This was the eighth-highest factor in order of importance for determining position on priority lists. Forty-two per cent of a survey of 2000 adults by Bowling (1996) affirmed that people who contribute to their own illness (e.g. through smoking, obesity, or drinking) should have lower priority for health care. Dolan et al. (1999) encountered the same attitudes in the initial responses of about half the members of a series of focus groups in Yorkshire. Braakenheim et al. (1990) report that half of a Swedish sample favoured priority for the prudent. Nord and Richardson (1995) found that 60 per cent of an Australian sample favoured priority to nonsmokers. But the interpretation of these findings is a complex matter, as I will discuss below.

Whether Scheffler is correct in his claim that theorists of justice in the Rawlsian tradition have attached little significance to personal responsibility is not entirely clear. It is true that in Rawls's *A Theory of Justice*, the role of personal responsibility is indeed circumscribed. Rawls argues that features of individuals or their circumstances that are morally arbitrary, or matters of luck, cannot serve as legitimate bases or justifying reasons for giving some individuals greater resources (such as income and wealth) than others. Thus, people who are born in favourable social circumstances, members of an advantaged social class, and those born with natural talents or aptitudes that are highly marketable, cannot be said to 'deserve' a greater share of income and wealth than others on these grounds (though society may choose to reward them for other reasons, for example, in the form of incentives). These are factors for which individuals are not responsible. Principles of justice, according to Rawls, should not reward individuals according to their good or bad fortune. What is fair, Rawls argues, is a system of equal rewards, or an equal distribution of income and wealth, unless rewarding the fortunate, for example, the better talented, proves to make everyone better off, especially the least fortunate. By this line of reasoning we arrive at Rawls's 'difference principle': inequalities in social goods are morally justified when even the worst-off benefit. Rawls suggests that the concept of 'desert' has a meaning and function only within the rules of justice of a society. These rules determine what individuals are entitled to, what are their legitimate expectations and claims on social resources, or what is deserved. Principles of justice, according to Rawls, should not be viewed as conforming to, or reflecting, some pre-institutional moral fact about what individuals deserve. As Christopher Woodward (1998) characterises Rawls's view, one looks to the theory to discover who deserves what, rather than the other way around.

But responsibility is not entirely absent from this view of justice. Rawls would hold individuals responsible for making do as best they can with their shares of social goods as determined by the principles of justice. For example, a person who has immoderate tastes or ambitions relative to others may find that her resource share goes less far in helping her realise aims in life, her 'good' or welfare. That she may fare less well than others in *this* regard is of no concern of justice, according to Rawls. Our preferences, as Rawls states, are our own concern or responsibility, and in this sense individual welfare is beyond the scope of social responsibility. What this implies about what justice requires in cases where individuals act imprudently as, for example, in 'squandering' their full resource shares, is open to argument. Clearly, Rawls rejects the view that expensive preferences should be collectively subsidised because the bearers of those tastes could thereby better realise their good or welfare. But the rejection of this view implies little about what the consequences should be, from the point of view of justice, of individuals acting recklessly or imprudently. Moreover, Rawls's theory assumes equal levels of need, abstracting away from actual interpersonal variations, and thus does not speak directly to

the question of whether people should be expected to avoid creating health needs through prudent behaviour.

In much of recent post-Rawlsian writing on distributive justice, however, and in particular in a number of key contributions to liberal political philosophy that appeared in the wake of Sen's (1980) influential essay, 'Equality of What?', personal responsibility plays a key moral role. In his influential papers on equality, Ronald Dworkin (1981*a*,*b*) tied distributive justice to the individual's willingness to take on certain risks. Dworkin distinguished between 'brute luck', the results of risks which are not deliberate gambles, and 'option luck', that which befalls a person as a result of gambles taken. In Dworkin's egalitarian schema, no one should be made to suffer on account of bad brute luck, while option luck, good or bad, may justly result in the increase or the reduction in a person's resources. But Dworkin imagines a scheme under which much of what would other wise count as brute luck can be considered option luck. This is an insurance scheme, which each person is free to accept or to decline, at market prices. Those who decide to keep their resources rather than buying insurance against bad brute luck cannot later claim an entitlement to compensation should their brute luck turn bad.

This schema remains egalitarian, but only in respect to a restricted range of outcomes in which individual choice does not play a role. Subsequent writing in this vein reinforced the key premise that what egalitarian justice requires is not equal resources overall, but rather that no one should be worse off than others for no fault of his own; or, in another formulation, for reasons outside his control. This, of course, permits (and perhaps even requires) inequalities in what is one's fault, or for what is under one's control. In Gerald Cohen's words:

> Egalitarianism does not enjoin redress of or compensation for disadvantage as such. It attends, rather, to involuntary disadvantage, which is the sort that does not reflect the subject's choice . . . the egalitarian asks if someone with a disadvantage could have avoided it or could not overcome it. If he could have avoided it, he has no claim to compensation. (Cohen 1989)

Cohen, Richard Arneson (1989, 1997), and the other so-called luck egalitarians (Anderson 1999) thus propose a route for egalitarian liberal theory of justice which promises to escape the alleged inattentiveness to the moral importance of individual choice, responsibility, and desert which Scheffler locates in Rawlsian philosophical liberalism. Here the emphasis on personal responsibility is as strong as in the right-of-centre political rhetoric of the past two decades: what results from free, informed choices, is a matter of personal fortune or misfortune. Where 'luck egalitarianism' parts company is over the distribution of well-being, or resources for well-being, for what is *not* the result of choice, that is, for what is brute luck. Luck egalitarians are strictly egalitarian here, whereas political conservatives are not: it is not part of the conservative view of the state that it should remedy cosmic injustice in this sense.

Luck egalitarians may differ from conservatives, also, in the degree to which they believe that that the plight of the poor and dispossessed in society (and that of the prosperous) is due to the consequences of choices they have freely made. It is a commonplace that more of one's station in life is attributed to the choices one has made, as we move rightward on the political spectrum. This is, as I will discuss shortly, a mixture of factual assumption and moral attitude. What is notable for the issue of personal responsibility for health, however, is that luck egalitarian philosophers have not been reluctant at all to assign responsibility to individuals in the domain of health. Indeed, choices involving health, such as smoking and drinking, have been the chief source of examples in this literature, as if the appropriateness of assigning personal responsibility in this domain were clearer than in others. Arneson, for example, would provide eyeglasses to a person born with myopia. But 'If a person became blind through deliberate and fully informed participation in a dangerous sport that often gives rise to injuries that result in blindness, it becomes questionable whether compensation is owed to him.' The clear implication of the use of these examples (none of the philosophical contributions addresses personal health policy issues as such) is that illness and premature death resulting from the choices one makes are one's private concern and place no claim on social assistance.

The luck egalitarians' lack of interest in health policy notwithstanding, this literature offers an elaborately reasoned rationale for an emphasis on personal responsibility in all the domains of health policy surveyed above. Those who lose in their gambles on health would deserve less consideration in rationing than those afflicted for reasons beyond their control; their worsened health state would not be counted as a social injustice; and, most generally, their sufferings might be understood as the price they paid for taking calculated risks. This is not to say that luck egalitarian writers are likely to see such policies as inherent in their approach; they tend to be left of centre, and their interest is for the most part on the egalitarian part of their message rather than on the inegalitarian implications I have alleged here. It is also open to luck egalitarians to recommend a pluralist view that combines or balances luck egalitarian provisions with a more traditional egalitarianism. John Roemer's approach to health resource allocation, for example, takes 'horizontal equity'—patients with similar needs receive similar treatment—as a starting point but uses luck egalitarian principles to choose among the many allocations that satisfy that requirement. (Roemer 2002; see also Roemer 1998) Nevertheless, these health policy conclusions tally with the medical examples that many luck egalitarians use, and it may be the case that what was intended as a largely egalitarian approach supports, in the end, a set of positions on health policy which are currently voiced only by the most conservative of commentators. As such, it represents the best-elaborated justification of these positions.

Nevertheless, I do not believe that these considerations make a plausible case for moving personal responsibility for health to the centre of health policy

concerns, except in the sense of suggesting effective strategies of health promotion. In the final section, I offer objections to doing so, addressing both the intuitive argument drawn on by conservative commentators and also the philosophical considerations presented by the luck egalitarians.

6.4. A ROLE FOR PERSONAL RESPONSIBILITY FOR HEALTH?

The notion that people should bear responsibility for the consequences of their voluntary choices makes up part of the bedrock of our moral and political culture. It is, in John Roemer's words, 'the cost of freedom', the dues we pay when we assert our right to self-determination as free adult citizens. The same freedom that permits us to act on our personal tastes and preferences, pursuant to our individual goals, plans, and values, reduces the scope of excuses for these choices should they turn out badly. Just as we expect to be left alone to decide which risks to take, others expect to hold us accountable for the consequences. If the condition of evading or denying responsibility for the consequences of our choices were the denial of the freedom to choose, the price would often be too high.

In the field of health, personal responsibility can be life-giving. Because health and longevity depend so much on whether a person adopts healthy living habits, encouraging people to take good care of themselves is a key to a population free of avoidable infirmity and premature mortality. The first steps toward adoption of healthier living habits are understanding the causal links between behaviour and health, and accepting and acting upon the notion that to this large extent, we can control our state of health in the future.

Despite these considerations, I will argue that personal responsibility for health deserves but a peripheral role in health policy. This conclusion should be reached, in my view, whether we think that personal responsibility should be central to our thinking about distributive justice generally. I will begin with a brief account of arguments against emphasising personal responsibility in the theory of justice, for if we reject the broader view we have little reason to support it in the special case of health. On the chance that these arguments are not convincing, I proceed to offer reasons to reject any attempt to move from the general thesis to its application to health. I close with a word on how a very limited, but constructive, role for personal responsibility might be envisioned within health policy.

6.4.1. *Justice and responsibility*

A full assessment of the debate over the role of personal responsibility in the general theory of justice is not possible within the confines of the present chapter. But it is worth noting some of the grounds on which such objections might be made. As Elizabeth Anderson points out in her paper, 'What is the point of

equality', some implications of luck egalitarianism are highly counterintuitive, and an important source of these problems is the view's preoccupation with individual choice. The fundamental idea, that bad (brute) luck deserves compensation but that the consequences of voluntary trades, gambles, risks, and tradeoffs do not, seems to yield appropriate concern on neither point. For example, such a regime would in effect punish many people who seem to have done no wrong, such as those who voluntarily refrain from work in order to care for dependents, or people who suffer when prudent risks go bad. These people will lose out in a luck egalitarian society because their deprivation stemmed from their free choices. On the other hand, luck egalitarianism might call for compensation to a person with better than average income who, through no fault of his own, had developed inalterable tastes for champagne and caviar. Anderson notes that while luck egalitarianism might seem at first sight to offer the best of capitalism and socialism by encouraging personal responsibility under the protection of a safety net against bad luck, it is also vulnerable to the charge that it combines some of the worst features of the two systems. In seeking to remove every difference in involuntary advantage, it is a utopian project to 'correct' for cosmic injustice, differences in prospects which are the fault of no person or society. At the same time, it assigns responsibility, and withholds assistance, regardless of need, whenever people make choices, standing in stern judgement of what, in actual human beings, is often a halting and uncertain effort to secure well-being. Its echo of the Elizabethan poor laws is a case in point; and the medical implications are another.

Given that most, if not all, of the philosophers contributing to the luck egalitarian literature hail from the left side of the political spectrum (in some cases, far from the centre), it is startling when the views they express on some issues exceed in their judgemental rigour positions which are prevalent even on the right. In this regard, the luck egalitarian position does not close the gap Scheffler alleged to exist between theorists of justice and contemporary popular political morality; it opens a new gap to the opposite side.

Again, the medical examples are the clearest example. The record shows that proposals to assign personal responsibility for health along the lines discussed in this essay have been relatively rare in any political milieu. Though proposals to this effect have appeared occasionally in the literature of medicine and bioethics, no significant figures in health policy or politics have taken up John Knowles's theme. Physicians, who in the United States tend toward the right, tend to be even more emphatic on the requirement that patients be cared for without regard to fault. The near-unanimity of liver transplant surgeons on the need to avoid 'moralizing' about the responsibility of alcoholics is particularly noteworthy, in light of the absolute need to establish priorities among patients whose lives hang in the balance.

It is true that some respondents in focus groups studied by health economists indicated that rationing should take into account the contribution of the individual to his or her own plight. But in nearly every case, those who voiced this

sentiment were in the minority. Moreover, several investigators noted that support for assigning lower priority to individuals at fault waned during deliberation. (Nord and Richardson 1995; Dolan et al. 1999; Nord 1999) And the proposition has been rejected outright by some deliberative bodies seeking to establish basic principles for prioritisation (Nord 1999).

Even the minority view on personal responsibility for health which appears to tally with the luck egalitarian verdicts may, in the view of one group of researchers, stem from quite different premises. Ubel et al. (1999) sought to distinguish between three grounds for assigning lower priority to patients whose behaviour may have contributed to their susceptibility to illness or injury. These respondents declined to change their priorities when told that the capacity for treatment, that is, likelihood of recovery with a given amount of resources, was the same for both sets of patients. But they were unmoved also when told that, after all, the patients' behaviour had not in fact been a contributing factor in their ill health. The reason that these respondents favoured lower priority for treatment for the likes of alcoholics and addicts was that they did not think that the lives of people of this sort were as worthy of care. This position, of course, is antithetical to the egalitarian emphasis of the luck egalitarian viewpoint which, superficially, leads to similar conclusions on personal responsibility for health.

The lack of correspondence between the luck egalitarian view and conventional morality need not be understood as any kind of rebuttal of the former; ordinary thinking about these moral issues might be wrong. But in this case the charge against Rawls and other liberals, that their views are seriously out of step with mainstream opinion, does not recommend luck egalitarianism as an alternative.

In the view of luck egalitarianism, informed and voluntary choices establish a moral fact, that of individual responsibility, from which important consequences flow. The more plausible alternative is of course that the more fundamental consideration is that of need. And it is the need of patients, without regard to responsibility, that is counted as the only relevant consideration in conventional medical ethics, and apparently in the mind of most members of the public as well.

A theory of justice which does not give a central role to personal responsibility need not dismiss the moral significance of choice entirely. It can be given due emphasis on instrumental grounds. Where people, or whole societies, might be harmed by relieving people of responsibility for the consequences of their choices, this accountability can be imposed. But where the consequences of doing so would, on the whole, be adverse, there would remain no reason to do so. J. S. Mill (1965) as noted by Richard Arneson (himself a luck egalitarian), urged that assistance be given to the impoverished up to the point at which further aid becomes harmful (Arneson 1997). The point applies still more forcefully to health, since it is very unlikely that the threat of forfeiture of health care can serve as a deterrent to risk taking, and in particular that the

harm that would be averted would be greater than that inflicted in denying care to the sick and injured.

6.4.2. *The context of personal responsibility for health*

These brief remarks do not tell against luck egalitarianism, or indeed against any theory of justice which has the consequence that individual responsibility for health should be assigned a central role in health policy decisions. This must be determined on the merits of these theories as general theories of justice. Though the medical examples are instructive, they appear in this literature only as illustrations; the tail does not wag the dog. This task cannot be undertaken here, but there are further considerations that tell against any attempt to put personal responsibility closer to the centre of the health policy stage, however well-founded the theory of justice which recommends doing so. These considerations are a mixture of practical and philosophical concerns.

Which actions are voluntary?

A moral viewpoint that puts great store on individual choice and responsibility must offer a criterion for determining which choices incur these obligations. The web of complications that stand in the way is, as we know from criminal law, extremely broad. But in criminal law we have at least a set of precedents and statutory specifications that guide us. In the case of personal responsibility for health, we have only the intuitions of one observer, set against that of another.

Moreover, actions only rarely have all the attributes—informed, voluntary, uncoerced, spontaneous, deliberated, etc.—that, in the ideal case, are preconditions for full personal responsibility. This is a particular problem in the case of lifestyles, which are matters of habit ingrained over many years and may have been learned from the individual's principal role models. The most dangerous elements of lifestyle, such as smoking or alcohol abuse, involve addiction, and the status of the smoker's decision to light up the next cigarette is anything but clear. One way around this problem is to assign personal responsibility on the basis of the initial decision to smoke, or the rational deliberation of the then-unaddicted individual to accept risk to health as the price of anticipated pleasure. This is the same strategy used by prosecutors of witchcraft in colonial Salem, Massachusetts, where both statute and common law viewed the acts of witchcraft as those of the inhabiting spirits and punished the witch for having permitted the devil to assume her shape, or by having communed with the devil by commissioning him to do acts of mischief. As with the magistrates in Salem, it is no easy matter to establish when and where this originating sin occurs, or to link the severity of the sentence to the degree of wrongful risk that we might imagine has been assumed.

At the most fundamental level, this requirement takes us directly to the ancient question of freedom of the will. Any policy debate which awaits resolution of these uncertainties is a long way from closure. John Roemer, a luck

egalitarian theorist, has taken up the challenge and offers, in the abstract, a method. Once again, a health example—responsibility for the consequences of smoking—is chosen as a focus for discussion.

Roemer's elegant proposal (1993, 1995) imagines that among factors leading to the act of smoking we can sort those over which the individual has control from those over which this is lacking. The circumstances of one's birth; one's gender; and perhaps one's social class, for example, may not be matters of one's choosing. But all of these seem to influence a person's pattern of tobacco use. Roemer recognises that different societies will identify the locus of control differently: the factors counted in one culture as beyond individual control may be regarded otherwise elsewhere. Roemer suggests that each society list the factors it wishes to recognise as beyond control, which in turn will delimit a 'type'—for example, female schoolteachers, or male steelworkers. These 'types', subject to different factors beyond individual control, will display different ranges of behaviour; for example, the steelworkers might smoke more than the schoolteachers. But, in Roemer's view, their degree of responsibility is not proportionate. Instead, Roemer suggests that the median individual in each type (as measured, for example, in the number of cigarettes smoked per day) should be assigned null responsibility, with accounting in a positive or negative direction proceeding from this midpoint. Roemer does not propose any particular list of such factors, and indeed is not committed to the premise that this question admits of anything other than a conventional answer. Still, in Roemer's view, proposal will ensure that, in every society, responsibility will be assigned in proportion to the degree of personal control, as understood by that society. In Roemer's words, this is 'A pragmatic theory of responsibility for the egalitarian planner'.

It is as a pragmatic theory for planning purposes, however, that the first questions arise. For the debate within societies, including Roemer's, over how much control individuals have over their behaviour, much of the controversy is precisely over which factors should be on this list. The prospect that different societies will construct their lists in different ways, however responsive to cultural differences, itself advertises the likelihood that all these lists will reflect not metaphysical bedrock—that is, whether the individual really does have control, or lacks it—but rather the consensus of opinion. A dissident who rejects this consensus will thus have no reason to change his or her views. Finally, it is not clear how finely these 'types' will be differentiated. Each individual's path to tobacco or obesity is distinct, channelled or inhibited by influences, opportunities, inclinations, and preferences unique to that person. Male steelworkers, even if they tend to smoke more than female schoolteachers, are an otherwise heterogeneous lot. If we classify like with exactly like, the groups will be too small and too homogeneous to admit of enough deviation from the median to generate Roemer's interesting result.

The question of what counts as 'a factor', that is, how precisely to account for a particular individual's behaviour, takes us directly back to the controversy, which the proposal was designed to resolve, over the possibility and

scope of free choice given the apparent determinants in one's internal and external environments. Arneson, a luck egalitarian, moderates the policy impact of this approach in pointing out that responsibility and desert are proportional not only to the consequences of one's actions but also to the difficulty one faced in attempting to be prudent. Pill and Stott (1982, 1985) found that working class respondents trusted health information if obtained from someone they knew, but seldom otherwise; individuals vary, to some extent as a matter of chance, in the sources of information offered to them. These variations at the individual level are unlikely to be measurable at the societal level. And even when they are, we may not agree on their significance. Studies of the origins of class differences in health-related behaviour, for example, demonstrate that unhealthy habits of living are strongly predicted by poverty in childhood and throughout the lifespan (Lynch et al. 1997). Some people transcend these origins and life prudently; there is at least as much disagreement over the freedom of the others to do likewise as on any other issue in this complex debate.

Adverse effects of assigning responsibility

On a less metaphysical plane, an important consideration weighing against emphasis on personal responsibility for health is the potential harm that the enterprise might inflict upon the enterprise of health care, and on social policy on health affairs. One plausible ground for the resistance of physicians to basing treatment decisions on assessments of personal responsibility is the prospect that the very useful and virtuous first instinct of the doctor or nurse, that of sympathy and care for the suffering patient, might be attenuated—put on an unstable hold, as it were, until the verdict of fault comes in. All of us gain if and when doctors think of patients as patients (a point which tells also against financial screening of patients at the hospital door). The same point can be made for societies as a whole: it is not salutary for people to become used to withholding sympathy for sick fellow-citizens unless and until it is established that those who are sick could not have stayed healthy back acting more prudently.

Arbitrariness of fault-finding

The empirical findings of Ubel et al., mentioned above, point to a further reason for concern with the notion of assessing personal responsibility for health. Ubel's sample, it will be recalled, included people whose concern was less with the contribution to illness made by voluntary choice than with distaste for the kinds of people who were thought to make these choices. An examination of the small literature, beginning with Knowles, that has proposed a greater role for personal responsibility reveals that not all choices leading to illness are counted alike. Those that are targeted tend to be sins—sloth, gluttony, lust, to

use their old-fashioned names—or to be behaviour, such as drug addiction, of the marginalised. We could, but do not, augment this list by adding other kinds of choices, also having a pronounced effect on health—of which we tend to approve. For example, the decision to have children, now that this involves a definite intention for many people, risks the health of the mother. A decision to postpone childbearing until advanced education has been completed markedly increases the risks for cervical and breast cancer. Daredevilry in sports and adventure risks life and limb, but the survivors are treated as heroes. If the moral principle underlying a move to give greater prominence to personal responsibility for health is that those who generate costs should pay for them, we should not expect that the only ones made to shoulder the costs are those who behave in ways that offend their neighbours. The point is not that a society must either demand compensation for all avoidable costs or else demand none. But the coincidence of two lists, that of lifestyles deemed burdensomely expensive and that of lifestyles deemed sinful, or of people deemed unworthy, suggests a different agenda from the stated one.

A sense of disproportion

Finally, a policy in which individuals are made to shoulder the burden caused by adverse consequences of choices they have made must make 'the punishment fit the crime': the burden reimposed on the risk-taker should be proportional to the burden imposed by the risk taking. But there is no metric to permit this. One problem is that similar behaviour in different people, and in different circumstances, represents quite different levels of risk (Japanese men, for example, are less likely to contract lung cancer from smoking than American men). Moreover, some habits which are unhealthy, even lethal for some are actually health-giving to others; alcohol is the outstanding example. And some habits, because they are taxed, may present a net economic gain to their societies. When cigarette taxes are high, for example, the added medical costs generated by the use of tobacco are more than offset by the payment of taxes and the elimination of pensions when smokers die. Those who have taken care of themselves, in that kind of regime, are the real threat to their neighbours' well-being.

Exaggeration of interpersonal differences

When critics of the emerging literature on the influence of social status on health attempt to explain away the evident health impact of social inequality, the thrust of their commentary is to shift responsibility away from social institutions and social structure and onto individuals. But to make this plausible, a series of exaggerations are required. First, almost all of the measured differences in health status between social groups is attributed to behaviour. Second, almost all of that behaviour is characterised as purely voluntary. But neither

claim is supportable. Though it is certainly true that working class adults in the United Kingdom and United States smoke more and weigh more than their well-to-do fellow citizens, on average, these differences account for only part the difference in health. One widely cited study which examined the leading risk behaviours put the figure at 15 per cent (Lantz et al. 1998). Though others give higher estimates (and there is not agreement on what these figures mean), no investigators explain virtually all health differences associated with social status to differing lifestyles. Moreover, where these behavioural differences do exist, the extent to which these can reasonably be viewed as free, informed, and voluntary choices is partial at best. Even assuming that some of the behavioural differences reflect different values, goals, or attitudes toward time, the remainder is occasion enough for concern over the fairness of the distribution of health.

In this light, proposals to attach importance in health policy to imprudent health-related behaviour involve a great deal of hand-waving. A sense of proportion is elusive. This should not be surprising. The administration of the criminal law, in which degree of responsibility must be determined as closely as possible, requires the elaborate and expense apparatus of the courts, attorneys, and lengthy trials. There is nothing comparable in the medical world, and there is no common law built of precedents, penalties attached to particular kinds of acts over many years, adopted in the interest of a smoothly functioning society. Nor is there likely to be, nor would it be desirable if there were to be.

6.4.3. *A positive role for personal responsibility for health*

Taken together, these considerations suggest that health policies that would give personal responsibility for health a central role face severe objections. The theory of justice which seems most supportive of this policy is questionable on its own terms, and in any case does not lend this support without a number of dubious accompanying assumptions. These reservations are joined by a number of objections of a more practical nature which suggest that a commitment to assessing personal responsibility for health might be wrong-headed, arbitrary, disingenuous, and even dangerous.

This account should not, however, end on that note. For a number of reasons, it is both practical and desirable that personal responsibility play a role (though not a central role) in public health and clinical medicine in the future.

One reason that personal responsibility for health should not be wholly ignored is the inherent desirability of free choice, and assumption of responsibility, for personal development and for the management of one's life course. Interpersonal variation in goals, preferences, and tastes—beyond the reckoning of the most omniscient managers—requires individual liberty so that circumstances can be tailored to the individual. Assumption of risk by the individual enables society to condone this freedom. This shouldering of the risk has numerous further benefits for the individual as well (though these can be

overshadowed by seriously adverse consequences). As Thomas Scanlon has observed (1988), choosing freely tells others that one is the kind of being capable of doing so, and this is a prerequisite to participation as a person in a society of free and equal beings. Looked at from a different perspective, requiring that people take a measure of responsibility for some of the adverse consequences of their behaviour can and should be taken into account by the chooser at the time of decision, lest their deliberations be distorted in leaving out the consequences of their actions for others. If this deters some actions, as high taxes dissuade teenagers from smoking, this is often a further benefit.

Above all, the fostering of a sense of personal responsibility for health can be part of a programme of 'positive freedom' or 'empowerment', a realization that actions taken can have a marked and positive impact on one's health, with radiating good effects on other dimensions of life and on other people. There is a risk, in stressing what the individual can do to stay healthy, that an individual's actual power will be exaggerated, and consequently that people can come to blame themselves, wrongfully, when they fall ill (Crawford 1977, 1979; Wikler 1985). But there is nothing inherent in the prospect of health promotion that necessitates this double message, and there is no reason to hold back from development of techniques of education and motivation which enable those who would favour the tradeoffs required to avoid illness and injury to do so efficiently and confidently. Neither self-blame nor that of others need figure in personal responsibility for health thus conceived.

6.5. CONCLUSION

Nothing in the foregoing denies what many take to be obvious, viz., that some people burden themselves and others in avoidable and undesirable ways by taking unjustified risks with their health. These actions can be as free, informed, and voluntary as any other, though, under this description, they must also count as rash and foolish. Ordinary morality would license resentment by people burdened as a result of these actions, and I have not provided any philosophical argument to the contrary.

The intuitions supporting this moral judgement, however, are insufficient to justify a strong emphasis on personal responsibility for health in the domain of health policy. Neither philosophical nor practical considerations give sufficient support for a policy of excluding patients who are sick as a result of their own imprudence from health services. Moreover, health deficits should generally be counted alike regardless of their source in policies aimed at reducing inequalities in health traceable to social status, and in targeting the burden of disease in public health interventions.

The theme of personal responsibility for health, perhaps more fortuitously labelled personal *opportunity* for health, may yet come to play a constructive role in health promotion, an element in efforts to educate and inspire individuals to take an active, informed role in staying healthy. The ethics of public health

have traditionally been oriented to the future, to positive outcomes of interventions that promise to relieve suffering. A theme of personal responsibility for health that focuses on what the individual may have done or not done to deserve assistance, however, begins its moral calculations with what has happened in the past. This account is difficult to square with the mission of public health as usually conceived, and if the conflict is not fully resolvable I suspect that the traditional values chart the best course for the future.

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