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John Harris

COULD WE HOLD PEOPLE RESPONSIBLE FOR THEIR OWN ADVERSE HEALTH?

*John Harris**†

I. INTRODUCTION

There has been much recent controversy about the ethics of holding people responsible for their own adverse health state and about prioritising health care delivery on this basis. It has been suggested that people who have been, and perhaps continue to be, responsible for their own adverse health should have a lower priority for care than their more "innocent" fellow citizens, or should bear a higher proportion of the costs of their care than others. Such suggestions have been made about smokers, people with HIV/AIDS, and people who participate in some dangerous sports or pastimes like climbing, pot-holing, and hang gliding.

There are obvious attractions in holding people responsible for their own adverse health state in so far as they are responsible for it, and for prioritising care on this basis. For one thing, it seems unfair that people who have, wholly or in part, caused their own illness should be treated while other "innocent" victims have to wait. Then there are obvious cost-saving advantages to a hard pressed health care system if it can reasonably demand a share of the costs of treatment in proportion to personal responsibility for ill health. For related reasons, health care providers would find it attractive to have a fair basis for prioritization in some cases. Finally, politicians are often attracted to policies which reinforce popular prejudices against unpopular groups. We have seen this in connection with the treatment of HIV/AIDS, and as the popularity and fashionableness of cigarettes declines, we are increasingly observing it in connection with smoking.[1]

There are of course powerful counter arguments to the attractions of

* Professor of Bioethics and Applied Philosophy and Research Director of The Centre for Social Ethics and Policy, University of Manchester.

† [The footnotes in this article comport to the system used at the University of Manchester.]

1. See for example Julian Le Grand *Equity and Choice* Harper Collins, London, 1981. See also an interesting critique of Le Grand's ideas Hugh V. McLachlan "Smokers, Virgins, equity and health care costs" in *The Journal of Medical Ethics* 21.4. August 1995.

such a policy. However, I shall not here be so much concerned with the merits of these claims, or the ethics of a policy of responsibility for health. Rather, I am interested in the question of whether it would be possible or desirable to attempt to implement such a policy however good the apparent justifications.

Let us grant a proposition that I believe to be false; that it is fair and reasonable to hold people responsible for their own adverse health (in so far as this lies within their own control) and to prioritise care on this basis.[2] Could we implement such a policy ethically and would we wish to bear the costs of so doing?

I will start by reviewing some of the ethical assumptions behind the idea that it is ethical and reasonable, *in principle*, to hold people responsible for ill health that they have wholly or partly brought on themselves. I will then turn to the issue of the sorts of social institutions we would have to create in order to pursue a *policy* of prioritising on the basis of personal responsibility for health.

II. Principle: Responsibility for One's Own Adverse Health State

Let's take the issue of smoking as our touchstone. There are two good reasons and one problem for discrimination against smokers when prioritising health care. The good reasons are that smoking is seen as both voluntary and unnecessary; its harmful effects are well established. The problem is the fact that smoking is addictive and that many people acquired the addiction before its harmful effects were known. Thus, they may not be fully responsible for such affects. Indeed, it might even be argued that governments have connived at these harmful effects for the sake of the tax revenue that smoking generates.[3]

However, let's assume that smoking is fully voluntary and ignore the issue of the contribution made by smokers to national economies. One consideration often adduced in favour of discriminating against smokers

2. For some of the arguments as to why it is doubtful that we should use age, life expectancy or merit to determine the allocation of public resources for health see my: "More & Better Justice" in Sue Mendus and Martin Bell Eds. *Philosophy And Medical Welfare*, Cambridge, University Press, 1988. 75-97. "Does Justice Require that we be Ageist?" - *Bioethics* Vol. 8. No. 1. January 1994. 74-84. "National Health = National Defence" in *Issues in Focus* August 1992. page 38.

3. There is some merit in the claim that smoking is even connived at or encouraged by the government for its revenue generating effects or because of the impact of the tobacco industry on society or as political lobbyists.

is the suggestion that when faced with a choice between treating a persistent smoker and someone who has diligently attempted to protect their own health by avoiding smoking, it would be unfair to prefer the smoker. The argument behind this judgment may be that the smoker should not be "rewarded" for her recklessness, while the prudent individual is "punished" for taking care of her own health. We should remember that it is not entirely true that a nonsmoker who is given a lower priority for treatment than a smoker has had the benefit of their virtue negated in some way. Nonsmokers do get benefit from their virtue; they are less likely to need health care. They do have their fair, deserved advantage over smokers. They have already been rewarded personally and statistically for their virtue. Should they be rewarded *again* by the public health care system? Does their virtue increase their entitlement to benefit from public health care?

Then there is the suggestion that the smoker should not be *preferred* to the nonsmoker; that such a preference would be unfair in that it rewarded virtue at the expense of vice. No one is, I think, suggesting that smokers should be preferred to nonsmokers; but should they have an *equal* chance of access to health care?

If they are given an equal chance of care and treatment then, of course, smokers will sometimes be treated while nonsmokers are not. It may be unfair in some cosmic sense when the virtuous suffer and the less virtuous prosper. But should we use public resources and even legislation to try to ensure that this does not happen? And if we do so, are we in danger of punishing people for their choice of lifestyle and doing so in a way that not only violates principles of natural justice, but creates additional and gratuitous injustice?

A. Double Jeopardy

It is sometimes said that giving smokers a low priority in the allocation of health care resources is justified; not as a punishment for smokers or a reward for the virtue of abstainers, but because to fail to do so would encourage dangerous and anti-social habits in the community and fail to give a much needed incentive to people to give up cigarettes. However, if the prospect of better health and a longer life on the one hand and fear of premature death from cancer or heart disease on the other does not act as an incentive, it is unlikely that the further fear of failure to get priority in medical care will add much to the incentives and disincentives already in place. If it is correct that refusals to treat or low positions on waiting lists

are unlikely to have much impact on behaviour, then discrimination against smokers in the allocation of health care resources will effectively function as a punishment and should be seen as such.

This raises a large issue which we have no space here to tackle adequately. It is the question of the appropriateness of allowing doctors, or indeed the health care system, to hand out punishments and rewards for behaviour that is quite legal. If this is effectively a form of punishment, and in so far as it is, it would be punishment without a hearing or trial by individuals who were effectively judge, jury, and executioner rolled into one. Moreover, there would be little prospect of appeal or remission of sentence. Not only is there a problem of double jeopardy—punishing people twice for the same offence (once by their contracting a condition caused by smoking and a second time by the refusing to treat that condition)—but there is also an insurmountable problem of natural justice.

There are two fundamental principles of natural justice that would be breached in such a case; indeed, which are breached when doctors refuse treatments on the basis of lifestyle. The first is that no one be condemned unheard; the second requires that no one be a judge in his own cause.[4] Where a patient is refused treatment and the consequence is that they suffer or indeed die for want of treatment that could have been provided to them and where this happens unfairly, they have certainly been condemned. In combination, these two principles provide a formidable objection to any attempts, whether intended or not, to use refusals to treat as a punishment for lifestyle.[5] I am far from convinced that people who take care of their own health should be rewarded more than their own efforts already reward them; or that people who fail to do so should be disadvantaged further than their carelessness has already disadvantaged them. But I do not think there are overwhelming arguments either way, at least so far as principle goes. But what of policy?

III. Policy

Suppose we tried as a matter of policy to hold people responsible for

4. See for example Stanley de Smith and Rodney Brazier *Constitutional and Administrative Law* Seventh edition, Penguin Books, Harmondsworth, 1994. pp. 602-617.

5. It is well established that just as measures intended as a punishment can operate, *de facto*, as a tax; so measures intended as an incentive or carrot, may, perhaps, operate as a punishment or stick. A classic example of the former was the fine (approximately 40 shillings) for soliciting. The fine was so small when compared with earnings that prostitutes treated it as a tax which they gladly paid for the privilege of working the streets.

their own adverse health state and distribute access to health care accordingly. What would it be like if we tried to do this?

If care and protection on the one hand and priority for treatment on the other is to vary according to an individual's own responsibility for her adverse health state, few would merit care and protection or have anything but a low priority. From creamcakes to car racing, from smoking to obesity, we are almost all "guilty" to some degree.

A. Prioritising on the Basis of Responsibility for Health State

At the moment, the focus of people's concern about the injustice of rewarding those responsible for their own adverse health state has centred almost exclusively on smoking and those with HIV/AIDS. This is, perhaps, revealing but hardly surprising. Smoking is now unfashionable and the focus of massive public health campaigns. Persons with HIV/AIDS have been the victims of extraordinary malice, stigmatization, and discrimination. Indeed, it has not been uncommon to hear talk of a distinction between "innocent" and "guilty"—those who acquired HIV via a blood transfusion or other medically administered blood products, and those who acquired the virus through sexual activity or intravenous drug use.

However, it is clear that any serious list of people who have or share responsibility for their own adverse health state would have to include a high proportion of the entire population. This can clearly be seen if we briefly rehearse a list of some of the anti-social behaviours that would have to be included in anything approaching a comprehensive attempt to catalogue appropriately responsible (or should we say "irresponsible") citizens.

Those who indulge in risky sports and pastimes (squash, football, rugby, pot-holing, climbing, hang gliding), those who don't indulge in sports and thus become unfit or obese, those who have less than an optimal diet (whether in the form of creamcakes, animal fats, hydrogenated fats, animal protein, etc.), or those who eat too much or too little would all have to be included. Then there are those who wilfully or recklessly engage in risky or unhealthy types of employment or frequent dangerous or unhealthy workplaces (fire officers, police officers, the armed services, factory workers, and health care workers).

Next we must consider those who wilfully and perversely choose to be dwellers in industrial cities with their inherent risk of pollution, road accidents, and violent crime. We know of course that certain geographical

locations are also inherently unsafe. This might be from such features as proximity to nuclear installations or naturally occurring radon, or because country dwellers are so often dangerously distant from a major hospital. It might be because people who live in the north of the United Kingdom or the south of Italy have significantly greater or lesser mortality and know or should know the dangers or benefits of such locations.

This brief survey of some of the ways in which people might reasonably be held responsible for their own adverse health state has revealed how extensive such responsibility might be. It has also revealed, to some extent, the scale of difficulty there would be in assessing such things as the degree of responsibility which people might have and the extent to which someone's choice of pastime, job, domicile, or even sexual partner was either fully informed or autonomous.

B. Knowledge and Information

Even if a metric for responsibility could be devised which would do justice to the different ways and circumstances in which people contribute, for better or worse, to their own health state, there remains the problem of information. If we are to distribute access to health care in the light of such responsibility, then health professionals and administrators need to have immediate access to the relevant information at the point of need or claim. To take just one example, in order to prioritise care, the casualty officer in the accident must know precisely the degree of responsibility of every casualty she sees and she must know it immediately. If this were not possible, huge injustices would occur and reasonable questions would arise as to the legitimacy of making those on whom information happened to be available bear the whole brunt of our attempts to redistribute health care according to this particular conception of a meritocracy of health. Even if, *per impossible*, such complete information could be made available, there remains the question of whether it would be desirable for other reasons (which would include privacy and the dangers of abuse) to support such comprehensive information gathering and monitoring.

IV. Conclusion

I hope two conclusions have emerged. The first is the far from overwhelming nature of the attractiveness of a proposal to hold people responsible for their adverse health state, and consequently, give such persons a low priority in the allocation of resources for health care. The

second is the pervasive nature of our responsibility for our own health state and the likelihood of it proving impossible to either devise a metric for the allocation of such responsibility or to cope with the ethical and practical problems of coping with the gathering, management, and availability of information that would be required.