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system. Therefore, in practice we punish the poor and those with low education. Braun has shown in Germany that almost twice as many bonus users were in the fifth quintile of earning than in the first quintile (Denier, 2005).

The example of keeping appointments seems at first glance uncontroversial. Keeping appointments is important to reduce cost and is also fair towards other people wishing to access services. However, patients with mental disorders or depression may have good reasons for missing appointments, thus implementation is complicated.

Over-diagnosis is a widely recognized problem in prostate cancer screening, but it has been reported in other cancers. In mammography there is a delicate balance between benefit and harm, since it hurts some women (Heath, 2009; Welch, 2009).

References

- Alberta to Seek Recovery of Health Costs Associated with Criminal Activity. (2009). *Canadian Medical Association Journal*, 181(3-4), E41-42.
- Bishop, G., & Brodkey, A. L. (2006). Personal Responsibility and Physician Responsibility – West Virginia Medical Plan. *New England Journal of Medicine*, 335, 756-708.
- Daily Telegraph of 23.11.2009
- Denier, Y. (2005). On Personal Responsibility and the Human Right to Health Care. *Cambridge Quarterly of Healthcare Ethics*, 14, 224-234.
- Doctors Warn Government against Removing Benefits from Alcoholics Who Refuse Treatment. (2009). *British Medical Journal*, 338, 971.
- German Doctors' Leader Calls for Debate on Rationing Services. (2009). *British Medical Journal*, 338, 1224.
- Heath, I. (2009). It is Not Wrong to Say No. *British Medical Journal*, 338, 1534.
- Meulen, R. T., & Maarse, H. (2008). Increasing Individual Responsibility in Dutch Health Care: Is Solidarity Losing Ground? *Journal of Medicine and Philosophy*, 33, 262-279.
- Schmidt, H., Gerber, A., & Stock, S. (2009). What We Can Learn From German Health Incentive Schemes? *British Medical Journal*, 339, 725-728.
- Steinbrook, R. (2006). Imposing Personal Responsibility for Health. *New England Journal of Medicine*, 355, 753-756.
- Walter, B. N. (2005). Responsibility and Health. *Cambridge Quarterly of Healthcare Ethics*, 14, 177-188.
- Welch, H. G. (2009). Overdiagnosis and Mammography Screening. *British Medical Journal*, 339, 182-183.

Personal Responsibility For Health: A proposal For a nuanced approach¹

Harald Schmidt

Introduction

The debate around responsibility for health, like many long-standing controversies, has become somewhat polarized. At one end of the spectrum, commentators make what might be called a “get-real” argument: they emphasize, for example, that lifestyle choices about physical exercise and the consumption of food and alcohol clearly do affect health outcomes; that successful treatment depends on patient compliance; and that peoples’ individual actions have a significant effect on whether a healthcare system can be run efficiently. Since it can make sense to say that in all these areas people are responsible for their actions, proponents then often assert that people should also be held responsible. This may entail that they suffer a penalty or disadvantage in cases where they behave irresponsibly. At the other end of the spectrum, commentators equally make a “get-real” argument. Here, it is stressed that the very concept of lifestyle choice can be cynical. It seems to assume that it is equally easy for all to be healthy, with some simply choosing an unhealthy as opposed to a healthy lifestyle. Even if the claim is not that it is equally easy for all, the assertion still seems to be that the options people have in their lives are generally such that all people could be healthy if only they decided to. But – leaving aside deeper philosophical debates about the freedom of the will – there is much reason to doubt that this is the case. For example, in presenting the final report of the World Health Organization’s (WHO) Commission on Social Determinants of Health

¹ Please note that major sections of the conference presentation were based on publications published prior to the conference (principally Schmidt, 2008, 2009a, 2009b). The author is grateful for the permission to reproduce the material in this form, and for the opportunity to make revisions in view of comments received since the publication, including in response to valuable feedback during the conference.

(CSDH), Director-General Margaret Chan noted: “The Commission’s main finding is straight forward: the conditions in which people are born, live, and work are the single most important determinant of good health, or ill health; of a long and productive life, or a short and miserable one,” (Chan, 2008). Hence, proponents of the social determinants of health view would argue that talking about a person’s responsibility to maintain a healthy weight is of relatively limited use in the case of a single unemployed teenage mother who grew up and lives in a deprived inner city borough with a high density of cheap fast food outlets, poorly maintained and unsafe parks, no affordable sports facilities, and so on. Holding her responsible for being overweight, by imposing some disadvantage or financial burden would amount to unacceptable victim-blaming, as not she, but the circumstances in which she lives, are responsible for her poor weight: as the CSDH report noted, instead of focusing on the causes of her poor health, more attention should be paid to the “causes of the causes” (CSDH, 2008).

In the following I argue that this often encountered polarization is misguided and unhelpful for making progress in the debate around responsibility for health. I suggest that, to some extent, it is due to confusions about the way we typically use the concept of responsibility, and I suggest a more nuanced approach that permits a debate about personal responsibility beyond the blame-game.

I begin with a review of how personal responsibility features in health policy in Germany, the UK, and the USA. I then draw out some common themes arising from these policies, and make a number of conceptual distinctions between different senses of personal responsibility. In the final section I set out a framework that, I hope, can help in planning, carrying out, and evaluating policies that seek to implement reasonable responsibility standards.

Personal Responsibility In Health Policy

Germany

Book V of the German Social Security Code (Sozialgesetzbuch [SGB V]) regulates the provision of statutory healthcare. Its norms are binding for some 200 sickness funds that provide care for approximately 90% of the German population (the remainder being covered by private insurance). Article 1 of SGB V has overarching function and is entitled “Solidarity and personal responsibility”. A characterization of both concepts is provided

in the wording of Article 1 that reads:

In the spirit of a mutually supportive community [Solidargemeinschaft] the task of the statutory health insurance is to maintain, restore or improve health of the insured. The insured have co-responsibility for their health; through a health-conscious way of living, taking part in appropriately timed preventative measures [and] playing an active role in treatment and rehabilitation, they should contribute to avoiding illness and disability, and to overcoming the respective consequences. The statutory sickness funds are to assist the insured persons through the provision of information, advice and services, and should encourage a health-conscious way of living [my translation].

The principal characterization of solidarity and personal responsibility is that the community as a collective, and people individually, are co-“producers” of health. The notion of co-responsibility has two important facets in this respect. First, it states that the “mutually supportive community” has a certain degree of responsibility for the health of each individual. In this sense, individuals are entitled to claims against the community for assistance. Second, it also implies that the community has certain claims against individuals. Leaving prudential benefits aside, the appeal to staying healthy has the aim of containing overall expenditure and opportunity costs. For all care needs to be financed by the solidaristic community, and cost can be reduced or at least contained if demands on the healthcare system are limited. Using services unnecessarily may also deprive another person in need of resources or medical attention, exacerbating resource allocation dilemmas. Article 2 SGB V on “necessity, cost-effectiveness, and personal responsibility” is unequivocal in stressing people’s obligations in this respect:

Services ... are to be provided by the sickness funds with due respect to cost effectiveness [Wirtschaftlichkeitsgebot] ... and insofar as the need for services is not attributable to the personal responsibility of the insured person. [...] Sickness funds, service providers and insured persons must seek to ensure the clinical and cost-effectiveness of services, which are only to be used insofar as necessary [emphasis added, my translation].

Article 2 raises the question of what exactly, in practice, the respective scope and limitation of solidaristic and personal responsibility should be. Is there a worst-case scenario in which solidaristic coverage would be refused? Article 52 SGB V sets out conditions under which statutory

sickness funds may limit funding for services, and the most recent healthcare reforms of 2007 included a noteworthy specification in this respect. In its pre-2007 version, Article 52 stated that insurers may demand a reasonable contribution to the costs of treatment if a person's need for healthcare is the result of engaging in a criminal activity. Solidarity and personal responsibility are interpreted in such a way that whoever harms the solidaristic community has lost the claim to having healthcare needs met at their exclusive expense. In such cases, financing healthcare can become a matter of personal responsibility. However, this responsibility extends to the costs only: for solidarity still clearly requires the criminal person to be treated by the healthcare services. Under the 2007 amendments, this principle has been extended to state that insurers may ask for equivalent contributions where people request treatment for complications arising from “cosmetic surgery, tattoos ... piercings,” or another “non-medically indicated” measures, and I will return below the some of the issues this raises.

In addition to these provisions, there are a number of initiatives that are framed as incentives for people to behave responsibly, as summarized in Figure 1. The common theme here is that a certain advantage, usually a financial one, such as lower insurance contributions, co-payments, or a lump-sum payment, can be obtained where people minimize their healthcare usage, regularly attend dental care check-ups, take part in preventive or wellness activities, or comply with treatment. All major sickness funds offer incentive programs and, typically, a single person can obtain an annual reimbursement of around EUR 50–100 for participation in different prevention measures (Schmidt, Stock, & Gerber, 2009). The different schemes have different rationales that may overlap. In the most benevolent interpretation, they are simply intended to improve people's health. Additionally, as the provisions of SGB V Art 65a set out, there is also the assumption that healthier people will require less healthcare expenditure. Lastly, in a somewhat more indirect way, incentive programs function similarly to schemes such as air miles or store loyalty cards. If programs are designed in such a way that they appeal in particular to the better off and healthy, incentives can help sickness funds attract “good risk” customers, who are likely to require less care, and contribute disproportionately more, as insurance contributions are income-tested. In this way incentive programs may help insurers secure a competitive advantage, and it is noteworthy that schemes such as the no-claims-bonuses (SGB V Art 53) were introduced under the 2007 Act to improve competition among statutory sickness funds.

Figure 1. Summary of provisions on personal responsibility for health in the German Sozialgesetzbuch V – SGB V (Social Security Code), 1988, last revised Jan 2007*

Incentives to limit use of healthcare services

Article 53 – “Personalised healthcare plans” [Wahltarife]

This Article provides that sickness funds may offer reduced contributions (or lower co-payments, where required) to those agreeing to take part in schemes thought to reduce the burden of morbidity and costs for the sickness funds, such as managed care programs. Sickness funds may offer what amounts to no-claim bonuses: Reductions of up to 20% of the annual contributions may be granted, capped however at 600€ maximum (or 900€, where several different bonus plans are combined) if the insured requires no primary care consultation leading to a prescription, or hospitalization over a year.

Incentives for compliance with dental check ups

Articles 55 and 56 – “Entitlement to services”

These Articles stipulate that statutory sickness funds must cover 50% of the costs for required dental replacements, with the other half falling to the insured person. The law also requires insurance providers to up their contribution by 20% of their initial payment, if, over a period of 5 years, adults have taken part in annual check-up programs (and under 18-year-olds in biannual ones). If there are no gaps over the past 10 years this is increased to 30%. However, if there are gaps, the insured persons have to pay their full 50%.

Incentives for ‘looking after oneself’

Article 65a – “Bonus for health-conscious behaviour”

This Article provides that sickness funds may offer bonuses to insured persons who regularly participate in preventive health-promotion, screening, and check-up programs. In practice, bonuses are provided in cash, reductions of insurance contributions, or goods, such as sports equipment. The law also specifies that bonus payments may only be made if savings for the sickness funds result from participation in the activities that are rewarded.

Incentives for compliance: chronically ill and cancer patients

Article 62 – “Thresholds for co-payments”

This article and subsequent interpretation by the Gemeinsame Bundesausschuss (G-BA) states that patients who suffer breast, colon, or cervical cancer will have to pay a maximum of 1% of their gross annual income as co-payments for treatments and medicines if they have attended counseling sessions on the advantages and disadvantages of the respective screens, and do not refuse treatment. In case of non-compliance, the cap is 2%. All other chronically ill are, at present, eligible for the 1% threshold.

*Note that this is an excerpt of the most relevant provisions. Note also that there is no official translation of the SGB V [all translations mine, HS].

United Kingdom

The UK, like Germany, has a long history of providing healthcare universally, even if the largely tax-funded single payer system differs in many ways from Germany’s social health insurance system. While personal responsibility featured explicitly and prominently in Germany’s health law for at least two decades, there is no similar longstanding acknowledgement of the concept in the UK, even if major Government reports and discussion papers explored different aspects of it (Halpern, Beales, & Heathfield, 2004; Wanless, 2004). However, in 2008, the 60th anniversary year of the NHS, the UK Department of Health (DH) held a consultation on a draft NHS Constitution, publishing a final version in January 2009. The document aims to set out the NHS’ fundamental values and principles, and includes a range of individual rights of NHS users and details their responsibilities (see Figure 2).

Figure 2. Excerpt from NHS draft Constitution – Section 2b on “Patients and the public – your responsibilities” (DH, 2009)

The NHS belongs to all of us. There are things that we can all do to help it work effectively and to ensure resources are used responsibly:

You should recognise that you can make a significant contribution to your own, and your family’s, good health, and take some personal responsibility for it.

You should register with a GP practice – the main point of access to NHS care.

You should treat NHS staff and other patients with respect and recognise that causing a nuisance or disturbance on NHS premises could result in prosecution.

You should provide relevant and accurate information about your health, condition and status.

You should keep appointments, or cancel within reasonable time. Receiving treatment within the maximum waiting times may be compromised unless you do.

You should follow the course of treatment which you have agreed with your clinician.

You should participate in important public health programs such as vaccination.

You should ensure that those closest to you are aware of your wishes about organ donation.

You should give feedback – both positive and negative – about the treatment and care you have received, including any adverse reactions you may have had.

The first paragraph differs from the following in that it is somewhat more general than the remaining provisions. Presumably what is meant here is something like “lead a healthy life, take part in preventative and health maintenance activities, attend check-ups if you are in the relevant age and risk group, and play an active role in treatment and rehabilitation”. The remaining items are then very specific, focusing on obligations that

would help ensure efficient operation of the NHS and generally also benefit the person concerned. During the consultation phase, the Constitutional Advisory Forum to the Secretary of State for Health (CAF) noted in its summary of the consultation exercise that the section on responsibilities was generally supported, but that there had been “anxieties about enforcement”. While some respondents took the view that “only those responsibilities with clear sanctions for individuals would have an impact”, others worried that “excessive or inappropriate enforcement might deter people from the services they need” (CAF, 2008).

The overall status of the responsibilities is – apart from one regarding interactions with NHS staff and other patients, which may entail legal sanctions – non-binding and merely aspirational. There is no mention of positive or negative conditions, be these financial or other incentives or disincentives, or other forms of rewards or penalties. Apart from pilot programs, the UK has so far not yet considered a broader rollout of incentive programs, although such options have been considered by different parts of the Government’s health policy advisory bodies, such as Health England (Le Grand & Srivastava, 2008).

It is noteworthy that the explanatory text of the Constitution’s consultation document stated unambiguously: “We have firmly ruled out linking access to NHS services to any sort of sanction for people not looking after their own health.” (DH, 2008). Perhaps some of the anxieties that the CAF reported might have been avoided if this, or a similar phrase clarifying the primarily aspirational nature of the responsibilities, had been included in the opening paragraph of the actual text of the responsibility section elsewhere in the Constitution, or in one of the accompanying guidance documents. In any case, the CAF’s report concluded that “The responsibilities in the Constitution as currently drafted do not need strengthening. The [DH] will, however, need to argue for an understanding of ‘responsibility’ that reaches beyond duties and sanctions to a concept linked to ‘mutuality’ – as taking responsibility with consequences for all rather than sanctions for individuals” for, “responsibility to the NHS is, at bottom, a responsibility to each other” (CAF, 2008).

USA

In contrast to Germany and the UK, the provision of healthcare in the USA is organized in a far less centralized fashion, and there is no universal coverage. Instead there is a mix of private and public provision of healthcare. Large employers offer their own health insurance, while others purchase coverage for their employees from private providers. Federal programs such as Medicaid provide services for the least well off, and people older than 65, and some who meet special criteria, are eligible for Medicare coverage. The Veterans Health Administration provides services for former military personnel. There are also significant differences in the way in which the different states provide services under Medicaid or Medicare, and while some view this diversity as an excellent opportunity to learn from different approaches, many view it as inequitable and problematic. Not least because of the diversity in providers of healthcare, there is currently no explicit single set of norms that would specify responsibilities of healthcare users in different areas. However, similar to the German initiatives on health promotion and incentives, there is federal guidance on the conditions under which wellness incentives may be offered.

The 1996 Health Insurance Portability and Accountability Act (HIPAA) sought to improve continuity of health insurance when individuals moved between providers. The Act established that a group health plan may not discriminate among insurance holders based on health factors such as disability or medical history, for example, by varying premiums. But HIPAA clarified that this did not prevent insurers from offering reimbursements for certain wellness programs, distinguishing between two types. First, in the case of what can be called “participation-incentives”, a premium discount, rebate, or reward may be given simply for participating in a scheme, such as a weight-loss or smoking cessation program. Second, in the case of what can be called “attainment-incentives”, a reimbursement may be given for meeting certain health status targets, relating to risk factors such as Body Mass Index (BMI) or blood pressure. A subsequent joint decision by the Departments of Labor (DoL), Treasury (DoT), and Health and Human Services (DHHS) in 2006 clarified that the reimbursement for attainment-incentives must not exceed 20% of the total cost of an employee’s coverage (i.e., the employee’s premium plus the employer’s contribution). Health reform bills before Congress at the time of writing propose to increase the level of reimbursements for attainment-incentives to 30%, with the option of 50% for particular initiatives, subject to

approval by the DoL, DoT, and DHHS. Both under current and proposed initiatives, for individuals for whom it is unreasonably difficult due to a medical condition, or medically inadvisable to take part in the programs, a reasonable alternative standard must be provided so that they can access reimbursements, although such exceptions are dependent on a certification from the employee's physician that plans may request. The Health Education, Labor and Pension (HELP) Committee's health reform bill "Affordable Health Choices Act" of 2009 required that a 10 state demonstration project would assess in particular: "changes in the health status of employees, the absenteeism of employees, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees", illustrating the range of motivations behind the scheme.

A controversial initiative at the state level regarding personal responsibility beyond wellness incentives was introduced in 2007 in West Virginia, where changes were made to the way in which Medicare would be accessed. The Medicaid Member Agreement, initially published in April 2006, and introduced under special provisions of the Deficit Reduction Act of 2005, is not a legal statute but its provisions are unambiguously binding for those enrolled. Prior to the Agreement, all Medicaid patients were able to access the same services. The new initiative changed this by creating two different plans. By default, eligible Medicaid recipients are assigned to the "basic" plan. Accepting the conditions of the Agreement, they may access the "enhanced" plan (see Figure 3). Those failing to comply with the Agreement will be reassigned into the basic plan, with the option of appealing and re-applying after 12 months where appeals failed. The "enhanced" plan is more comprehensive and includes, for example, smoking cessation programs, nutritional education, weight management programs, and mental health and substance abuse services. The "basic" plan limits non-emergency medical transportation and prescription drugs (a maximum of four prescriptions per month, although, by contrast, there is no limit in the "enhanced" plan). The Agreement has been phased in since early Spring 2007, and the first evaluations are expected to be published shortly after the time of writing.

*Figure 3. West Virginia Department of Health and Human Resources: Medicaid Member Agreement, April 2006**

1. I will follow the rules of the West Virginia Medicaid program.
2. I will do my best to stay healthy. I will go to special classes as ordered by my medical home.
3. I will read the booklets and papers my medical home gives me. If I have questions about them, I will ask for help.
4. I will pick a medical home within 30 days or one will be picked for me.
 - I will go to my medical home when I am sick.
 - I will take my children to their medical home when they are sick.
 - I will go to my medical home for check-ups.
 - I will take my children to their medical home for check-ups.
 - I will take the medicines my healthcare provider prescribes for me.
 - I will show up on time when I have my appointments.
 - I will bring my children to their appointments on time.
 - I will call the medical home to let them know if I cannot keep my appointments or those for my children.
 - I will let my medical home know when there has been a change in my address or phone number for myself or my children.
5. I will use the hospital emergency room only for emergencies.

*Note that only the first part of the agreement has been reproduced here, concerning the responsibilities of Medicaid members. The full agreement, which lists member's rights in the second section is available from: http://www.wvdhhr.org/bms/oAdministration/Medicaid_R redesign/redesign_MemberAgreement20060420GW.pdf

Summary

Personal responsibilities set out in policy and law in Germany, the UK, and the USA specify obligations with three different directionalities. First, there are responsibilities directed at oneself, to stay healthy, or to regain health where it was poor. Second, there are responsibilities where the object is the health of others, for example those under one's stewardship (children or the elderly), or otherwise people whose health may be better or worse, depending on how we act (for others' benefit we ensure that we

do not spread infectious diseases, donate blood, etc.). Third, there are obligations towards the healthcare system, to ensure its efficient operation. Closely connected to the question of to whom one is supposed to have some obligation is the question of on what grounds. An at best implicit rationale is that health in itself is a good that should be realized, or, in a more instrumental sense, that good health is something that is necessary for accomplishing things that matter in life. More explicit rationales are that we have obligations not to harm others, and that behaving responsibly and being healthy will contain or reduce healthcare expenditure, or enhance fairness, as more people are able to access healthcare. Insurers or self-insured employers are also likely to consider the potential of incentive schemes to help them attract “good-risk” enrollees, who are likely to have lower morbidity, fewer sick days, less absenteeism, and greater productivity.

Responsibilities are set out with different status. In the German case, they form part of hard law (even if the sickness funds have some discretion in implementation), in the UK case they are purely aspirational, and the incentive policies set out in the USA depend on whether insurers make use of the provisions for wellness programs. However, in the case of West Virginia’s Medicaid Membership Agreement, implications for healthcare users are, in principle, as direct as in the German situation. While some schemes are framed explicitly as “sticks” or penalties that are imposed where people do not comply with their responsibilities, the majority is presented as incentives (or “carrots”).

Conceptual Distinctions

The concept of personal responsibility, both as implied by policies such as the above, and as reflected in the broader academic debate warrants a closer inspection. For many, the ascribing of responsibility is intrinsically linked to holding someone responsible, and proponents argue that responsibilities without sanctions appear pointless, while opponents caution that imposing sanctions often entails the risk of penalizing people unduly. But this dichotomy is inadequate, for there are a range of different things people may mean when they say that “person X is responsible for p”. Sometimes, distinct notions are made explicit, but other times, several meanings may be in use simultaneously, whether explicitly or implicitly. Much confusion arises from not distinguishing clearly between

these different meanings, or from not being explicit about which sense is intended in endorsements or criticisms of particular responsibility-related policies (see also Figure 4).

Figure 4. Personal responsibility in philosophy and ethics

A range of different characterizations can be found in the literature. The following examples have been set out to be applied in the context of healthcare, or are otherwise directly applicable:

- “causal ... responsib[ility vs.] responsib[ility] ... [as] being at fault and accountable” (Wikler, 1987)
- “role responsibility..., causal responsibility ..., responsibility based on liability” (Dworkin, 1981)
- “responsib[ility] for ... choices ... [vs.] responsib[ility] for the consequences of ... choices” (Cappelen & Norheim, 2005)
- “prospective ... [vs.] retrospective responsibility”, (Werner, 2002)
“forward-looking ... responsibility [vs.] backward-looking ... responsibility” (Feiring, 2008)
- “substantive responsibility ... [vs.] responsibility as attributability” (Scanlon, 1998)
- “agent responsibility [vs.] consequential responsibility” (Stemplowska, 2008)
- “individual responsibility for reasons of ... fairness, ... utility ... self-respect ... autonomy ... human flourishing” (Brown, 2005)

At the most basic level, it is important to distinguish whether we are ascribing responsibility in a backward-looking sense (where, for example, we assess someone’s past behavior that is correlated to some health outcome) or in a forward looking one (where we may want to specify what people should do in the future). In a backward-looking sense, the phrase “person X is responsible for p” may mean:

1. X has played a certain causal role in having brought about p.
2. X has played a certain causal role in having brought about p, and should recognize this.
3. X has played a certain causal role in having brought about p, should recognize this, and try to avoid doing so in the future.
4. X has played a certain causal role in having brought about p, should recognize this, try to avoid doing so in the future, and make good any costs

(with or without being blamed) for reasons of distributive justice.

5. X has played a certain causal role in having brought about p, should recognize this, try to avoid doing so in the future, make good any costs, and, in cases where X requires treatment, may be given a lower priority than patients whose behavior played none or a lesser role in contributing to their healthcare needs (typically with attribution of blame).

It is not uncommon for commentators to focus on the last type only, and/or to jump straight from the first to the last type, assuming that having established some degree of causal or role responsibility, a person must also be held responsible (see Cappelen & Norheim, 2005; Daniels, 2007; Heath, 2008). But this is far from necessary. For example, the concept of solidarity as featuring in the German SGB V – featuring in a less value-laden sense also in most risk-pooling arrangements underlying both public and private health insurance – may mean that we are quite clear that a person’s action played a causal role in producing a bad health outcome, but that this does not reduce the person’s claims on the community (Segall, 2007).

Nonetheless we may find it useful to draw on some notions of responsibility, whether in abstract policy, specific prevention campaigns, or consultations with healthcare professionals. For example, in a given case where a person is responsible in one of the first three senses there may remain some degree of freedom for personal action and behavior change even if environmental constraints have played a role, perhaps even a major one. Realizing the scope for action in this area is important for avoiding fatalism and resignation, which may have a powerful grip on people struggling to maintain or improve their health. While it is difficult to disagree with the strong emphasis that proponents of the social determinants of health approach put on the general need for improving environmental conditions, an exclusive or overly strong focus on the environment can overlook the degrees of freedom that people have, even in constrained conditions. For people to take action, then, it is necessary for them to realize the extent to which they contributed to, say, a bad health outcome, and, in this merely functional sense, to realize that they are, and can be, responsible. An important qualification is of course Kant’s old adage of “ought implies can”, which has particular relevance in this context. For it would be pointless, if not cynical, to specify responsibilities where, due to strong environmental constraints, it is impossible for people

to act accordingly.

It is also important to recognize that talk of responsibility in a forward looking sense is in many ways quite different from the more common backward-looking perspective. Hence, what we may mean here when we say that “person X is responsible for p” may be:

1. X should do p as no-one else can, in principle (or will, practically) do p for X (e.g., exercise more, eat less).
2. X should do p, as this will be good for the health of X.
3. X should do p, as this will be good for the health of others, or the operation of the healthcare system, even though X won’t be penalized if p is not done.
4. X should do p, as this will be good for the health of others, or the operation of the healthcare system, and X knows that a penalty will be imposed if p is not done.

Again, it is far from necessary that the first or second type of responsibility, which may be called prudential responsibilities, automatically lead to the last type, which, together with the third, may be called responsibilities of justice. For example, paragraphs one, two, four, and seven of the responsibility section of the NHS Constitution helpfully emphasize the value of prudential responsibilities. Some health-related behaviors simply require that people individually do them, as no-one else will do them for them, and not even the most optimal environmental conditions will make them do them, in some sort of mechanistic way. It is in this somewhat banal, but nonetheless crucially important sense, that a range of health-related behaviors are personal responsibilities. Noting them and appealing to them in health promotion activities is relevant since – environmental constraints permitting – in a significant sense it is up to us to decide on whether we wash our hands regularly, brush our teeth, exercise, see our GP when we are sick, are honest about our health-relevant information, take part in public health programs, and so on. Advocating such responsibilities can result in clear personal benefits and is also likely to complement the social determinants of health approach as it can help identify those social or other structural constraints that make it difficult for people to live healthily.

Equally, the NHS Constitution’s responsibilities one, four, six, and seven, and the general characterization in Article 1 of the German SGB V clarify that achieving good health is necessarily a co-production process, requiring both individual and social action. Forde and Raine (2008)

have characterized co-production as the idea that: “Responsibility for better health should be shared between society and the individual, ... society’s efforts for health improvement should be dovetailed with individuals’ and families’ efforts.” Central to their discussion is that policies are required that “support ... people to engage with decisions about their own health”. This includes health-literacy campaigns and may, in principle, also speak in favor of financial incentive schemes that feature prominently in the German and US initiatives.

Even if the reader is persuaded that it does make sense to accept a more nuanced picture of what should be understood by the concept of personal responsibility for health, and that a focus on blame and punishment detracts from preserving an important core of the concept that can be independent of sanctions, at this stage a question that clearly remains is how such an approach should be put into practice. To this I turn next.

A proceduralist Account For Ensuring Fairness in Personal Responsibility Policies

In one sense, the question of health responsibilities might simply be a matter of choosing “the right” normative framework. Various political perspectives have different ways of explaining which of the above notions of responsibility should be central, and which ones should be more peripheral. Equally, there are different accentuations of personal responsibility in philosophical contributions, such as luck, egalitarian ones (Arneson, 1997; Dworkin, 2000; Roemer, 1994, 1995), or communitarian (Callahan, 1998), or libertarian accounts (Engelhardt, 1981). However, there are two principal problems with this approach. First, in value pluralistic societies, agreement about what constitutes the right framework remains generally elusive. Second, even if we suppose that we are able to find a country in which all residents (or just citizens) can agree on a single monolithic theoretical account, whether political or philosophical, such value systems are typically of a very general nature, and do not tell us ad more geometrico how to decide in designing and evaluating concrete policies.

Of course, this situation is not unique to the health responsibility debate. For example, regarding the central question of resource allocation, which, with Norman Daniels, is: “How can we meet health needs fairly when we

can’t meet them all?” we are equally faced with a range of substantive positions that offer different perspectives. To make progress in practice, in a proceduralist approach Daniels suggested supplementing general principles of justice with fair processes for limit-setting, and draws on the framework of Accountability for Reasonableness, initially developed with Jim Sabin (Daniels & Sabin, 1999). This approach requires that policies meet four conditions concerning publicity, relevance, revision and appeals, and regulation. The relevance condition is specified in its briefest form as follows:

The rationales for limit-setting decisions should aim to provide a reasonable explanation of how the organization seeks to provide “value for money” in meeting the varied health needs of a defined population under reasonable resource constraints. Specifically, a rationale will be “reasonable” if it appeals to evidence, reasons and principles that are accepted as relevant by [fair minded] people who are disposed to finding mutually justifiable terms of cooperation. Where possible, the relevance of reasons should be vetted by stakeholders in these decisions ... (Daniels, 2007)

Below, I adopt the Accountability for Reasonableness approach to make progress with the debate around personal responsibility for health in a value-pluralist society. In order to specify the areas in which justification is owed under the relevance condition, I set out a number of “tests” that concern the impact of a policy in the planning, monitoring, or evaluation phase on key normative and structural values and components that are integral to practically all healthcare systems. These tests concern evidence, rationale, and feasibility; intrusiveness; equity; solidarity; attributability and opportunity of choice; affected third parties; and coherence (see Figure 5). I illustrate their relevance by focusing on financial incentive systems to promote health responsibility. This illustration is somewhat general, as the framework is not applied to a single specific policy, but comments on specific features of programs noted above. Nonetheless the discussion should help illustrate how the approach can be used in practice.

Evidence, Rationale, and Feasibility

Above, several different rationales were shown to underlie the policy initiatives in Germany, the UK, and the USA. The first step in planning personal responsibility measures is hence to justify these publicly, and to enable those affected by them to contribute their views, which includes possible arguments they would make to reasonably reject them, or request modifications. Insofar as incentive programs are offered on a voluntary basis, people might not be concerned about the rationale of using them to improve health. However, in practice, the implementation of incentives typically means not just that some people are offered an additional “carrot”, but that those not taking part are denied one, and, in effect incur higher healthcare costs. For example, based on the average cost of healthcare coverage, the 20% reimbursement cap that is permissible under current US regulation can allow

Figure 5. Seven tests to evaluate the appropriateness of health responsibility policies

Evidence, rationale, and feasibility

What are the policy’s principal rationales and goals? Have they been justified in an open and transparent manner, with opportunity for comment by all those affected by the policy? How sure can we be that the policy will achieve its aim, in principle and in practice? Are the required efforts and cost proportionate

in view of the goals?

Intrusiveness and coerciveness

Are there ways in which the goal of the policy could be achieved in less intrusive ways? If not, is the extent of intrusiveness justifiable in view of the expected benefits?

Equity

Are there some groups (such as particular socio-economic, ethnic, or regional subgroups) who are likely to experience disproportionate benefits or burdens as a result of the policy? At what point would it be reasonable to reject a policy because of inequitable impact?

Solidarity/risk-pooling

Insofar as the healthcare system has an implicit or explicit principle of solidarity or risk-pooling: how does the policy affect it? If it should undermine solidarity or risk-pooling: are all affected clear about this, and can the effect be justified?

Attributability/opportunity of choice

To what extent are penalties or rewards based on actions that can be attributed to people’s free and voluntary choices? Where peoples’ opportunity of choice is limited: can waivers or alternative standards be implemented? Should rewards be given, even if people have not changed their behavior, but just happen to satisfy the policy’s criteria?

Affected third parties

Does the policy have an effect on the relationship people have with, for example, their physicians or employer? Insofar as physicians are involved in assessing whether or not someone has complied with their responsibilities: is their involvement justifiable and accepted by them and their patients? What information should employers have (or not) about people’s compliance with responsibilities?

Coherence

How does the policy compare with standards of responsibility, attributability, and blame in other areas of social policy and the law? Since tensions can be resolved in more than one way: in which way should they be addressed?

for a variation of as much as 965\$ per year for a single employee; if the employee’s family is also covered, the differential could be 2675. The German programs generally operate on lower levels, but in principle the same issues are raised. In both cases, what is offered as a “carrot” will seem to many far more like a “stick”. In view of this situation it is desirable to justify implementations such as the above as reasonable, and it is especially important to provide evidence that the programs have a reasonable chance of success, both in terms of helping people change their behavior, and in terms of achieving goals such as cost reduction, that, as noted, also feature prominently. A major initiative that attracted much

recent attention by US policy makers was the Healthy Measures program established by Safeway, whose CEO frequently claimed that it had helped reduce expenditure. However, robust evidence to support these claims has not been provided to date, and recent investigative journalism raises substantial questions about their veracity (Hilzenrath, 2010).

More fundamentally, it is also not clear that longer, healthier lives will lead to reduction in healthcare cost. Pieter van Baal and colleagues used a dynamic population model to analyze healthcare data from The Netherlands in order to estimate lifetime healthcare cost conditional on the presence of risk factors. They found that expenditure was highest for the healthy (defined as: non-smoking, BMI between 18.5 and 25: healthcare cost from age 20 was estimated to be €281,000) and lowest for smokers (€220,000), with obese people in an intermediate position (€250,000), largely due to differences in the longer life expectancy of healthy people, and associated cost for care (van Baal et al., 2008). However, there is also an as yet unresolved dispute about whether increasingly longer life expectancy will in fact lead to higher levels of morbidity and care needs (known as the “medicalization thesis”) or whether longer life will mean that the period in which care is needed is simply condensed over a shorter time than previously (the “compression thesis”) with some arguing that this will not lead to overall increases in healthcare expenditure and others less convinced about possible savings. These and further questions, such as those around the impact on productivity in the workplace, all require extensive study of empirical and modeling data and, clearly, not even an attempt at a conclusion can be offered here. However, it is noteworthy that some of the hard questions of distributive justice around people’s responsibilities may actually turn to a significant extent on an empirical analysis of the effectiveness of incentive programs in practice, and the actual costs associated with particular risk factors and ageing populations, which are often simply assumed. Of course, the mere fact that prevention programs may not lead to cost savings in the longer term does not mean that they should not be carried out. But it would seem that other reasons would need to be given in their support. Evidence on the total cost of poor health might also lead to a wider recognition that assessments of people who fail to behave responsibly (in the senses implied by incentive programs that seek to encourage a healthy way of living) would need to be re-adjusted, as, to some extent, the argument can be made that rather than costing society more, smokers and obese people have in fact “paid their way”, largely by

dying earlier. Equally, such programs would need to be advertised in a way that avoided some form of unwarranted health paternalism or risk of stigmatization of already vulnerable groups, such as obese people.

Intrusiveness and coerciveness

Incentive systems are generally framed as not being particularly intrusive or coercive, as it is commonly suggested that people are free to use them or not. However, high levels of reimbursement, as illustrated above, raise doubts about the extent to which people are free not to make use of the offers. Providers also differ in the way they advertise their programs, and it is not uncommon for insurance holders to receive frequent reminders by mail or other means. Such initiatives may be perceived as “nannying” of forms of “healthism” and may have a counterproductive effect on health responsibility attitudes.

Programs that reward participation in presymptomatic check-ups, such as cancer screens, may also be intrusive in the sense that they bring uncertain and unwelcome knowledge about disease susceptibility, possibly leading to anxiety or confusion, even if the degree of intrusiveness can be mitigated by focusing on providing information with suitable confidence intervals and the option for people to discuss any questions they may have. The level of intrusiveness or coerciveness therefore needs to be considered carefully, and is closely linked to the questions regarding evidence and rationale: poor evidence and rationales combined with highly coercive or intrusive measures would make for rather bad policy.

Equity

The fairest way of providing health interventions is often simply to make them available universally for all: this avoids stigmatization and leaves uptake to people who are suitably motivated. On the other hand, such approaches can be prone to problematic self-selection biases. Here, not only the penalizing effect resulting from cost-shifting that has been noted above needs to be considered (which is likely to disadvantage most those who are generally poorer in health and income), but also the question of whether unequal reaping of benefits should be acceptable. For example, it is not implausible to assume that a sizable proportion of those who are eligible for incentives would have behaved in the way that “earned” them the reimbursement anyway, simply because they follow a healthy way of living. In the “post-incentive” phase, they therefore act no different than in the “pre-incentive” phase. Where reimbursements are offered for meeting

certain health standards, such as BMI or blood value levels, or for activities such as an active gym membership or attending yoga classes, there are questions about whether the better-off benefit more than the worst-off. Certainly, initial data from Germany suggests that this is the case: 19%, or almost twice as many people belonging to the fifth (least poor) quintile, used incentive programs in 2004–2005 as opposed to 11% of the first (poorest) quintile (Braun, Reiners, Rosenwirth, & Schlette, 2006). Trends since then have pointed in the same direction (Schmidt & Doran, forthcoming).

Wellness or prevention incentives aside, programs that offer reimbursements for not utilizing primary care consultations or hospitalizations over a year (see Figure 1, Art 53) raise some very similar issues, and moreover may lead to a problematic form of “health gambling”: if the insured persons stay healthy, they may make a gain. However, if they banked on redeeming the incentive and end up requiring treatment, they may either be faced with a financial “loss” of varying degrees or, alternatively, may seek to avoid or delay necessary prescriptions or even a necessary hospitalization. The effect is likely to have more impact on those who are worse off financially, who may, nonetheless, be more tempted to try their luck. On the whole though, such initiatives will be of more interest to the young and healthy, and less to the frail or elderly – unless they are very lucky gamblers. Here, again, inequitable distribution of both benefits and burdens needs to be assessed.

Solidarity

Solidarity, as noted above, is a value that explicitly underlies the German statutory health insurance system, and in practice it means that the healthy support the sick; the young support the old; the employed the unemployed; and the better off the worse off, as contributions are income tested. To a significant extent, key aspects of the principle can be found in other insurance systems that rely on risk-pooling, even if the value would be more implicit in such cases. In one view, it could be argued that incentive schemes have nothing but a positive effect on solidarity, as they reward those who behave in ways that are assumed to make the healthcare system more efficient. As noted above, the truth of the economic element of this assumption depends to some extent on empirical evidence. However, there is also a more conceptual point to be made. For where inequitable uptake as described above should occur, and the worse off face a higher financial burden than the better off,

key aspects of the principle of solidarity risk being undermined.

In a lesser sense, solidarity might also be undermined in that the meritocratic element behind incentive programs might not be appreciated equally by all insurance holders. Those who are not able to mobilize themselves to actions for which reimbursements are provided might envy those who do and find any competitiveness at odds with a conception of solidarity that relates to a union of people who have come together to offer mutual support rather than join in a race for incentives. Alternatively, finding that they are not able to perform rewarded behavior may result in a feeling of disappointment and may lessen their sense of belonging to the solidaristic community, or feeling that their needs are being cared for appropriately.

Attributability and Opportunity of Choice

As highlighted above, there are a number of ways in which it can make sense to attribute a good or bad health outcome to a person without linking this assessment to questions of praise or blame, or reward and punishment. Often, causal attributability will only be partial, as a number of other factors, typically arising from the environment within which a person lives or works also need to be considered. Where negative sanctions are contemplated – whether framed as incentives or disincentives – there needs to be good evidence that the people concerned had a reasonable range of opportunities to avoid what is regarded as a poor health outcome. In this regard the requirement in the U.S. regulations that an alternative standard must be provided for those who feel unable to meet the standards required by particular attainment incentives programs are a useful way of acknowledging that peoples’ circumstances differ, and that some programs will simply be incompatible with the range of choices people have in their daily lives. However, the provision is also very narrow in focusing on medical conditions only, and hence ignores much of the data that come from the social determinants of health literature, which demonstrates that the socio-economic situation of a person can imply equally powerful, and often directly linked, constraints. Care is hence required in devising policies that offer fair chances to all.

The question of attributability also raises another issue that is related to the difference between forward- and backward-looking responsibilities. Above it was noted that the most recent German health reforms had introduced provisions that would require people requesting treatment for a non-medically indicated measure such as cosmetic surgery,

tattoos, or piercings to share some of the cost of treatment. I leave aside here an exploration of the arguments around whether such actions should be seen analogous to requiring treatment that may arise from engaging in a criminal action; that was initially addressed in Art 52 SGB V – in my view they simply are not. However, beyond this question the policy raises other relevant issues, as it is introduced retrospectively and without a cut-off date, and hence people concerned could not have been aware at the time they received their tattoo, piercing, or beautification, that doing so would also mean they could be faced with a greater financial burden when things go wrong. This illustrates that the relationship of forward- and backward-looking responsibilities is such that the former are required to be put in place first, in order for the latter to have strong legitimacy and acceptance.

Affected Third Parties

Depending on implementation, incentive systems may not involve any third parties; for example, in the case of the German incentives for regular dental check-ups, reception staff may log a visit electronically, and the patient then receives the rebate for any work that needs to be done. However, the determination of other types of incentive-qualifying behavior may involve healthcare staff; for example, they are required where rewards are made if key health data, such as blood pressure, stay within a certain range over a year. Those on no-claim plans may wish that healthcare staff was not involved if they require treatment before completion of the qualifying period, and issues may arise where patients appeal to staff not to record their appointment. Equally, the US requirement that a physician needs to attest that a person is unable to meet a standard for an attainment incentive can lead to similar situations. Most of these situations are likely to lead to awkward situations, but depending on the size of the incentive at stake, more serious tensions may arise, and healthcare professionals may not be pleased with being put in an actual, or perceived, policing position, which may have a detrimental effect on the doctor-patient relationship (Bishop & Brodkey, 2006).

Another relationship that needs to be considered is that between incentive program participants and their employers, in particular in cases where incentive programs are offered in the work place. For obvious reasons, employers are likely to be interested in their employees' health status, and while most countries have in place data protection legislation that

regulates access, the implementation of wellness programs provides opportunity to review compliance and adequacy.

Coherence

The coherence test asks how benefits or disadvantages that result from a personal responsibility policy fit in with the wider context of social policy and law. It is probably more relevant for cases where explicitly penalizing sanctions for contributions to a bad health outcome are envisaged, and, for example, the concept of contributory negligence as applied in jurisprudence regarding road traffic accidents offers an approach where similar questions are addressed on a day to day basis. However, while coherence across different areas of social policy and the justice system more widely is clearly desirable, possible conflicts can be resolved either by aligning a particular health responsibility policy with the wider context, or, alternatively, it may be that the health context shows the relevance of significant constraints that require us to re-assess the justification of other policies, provided they are similar in all relevant aspects. In any case, an evaluation of the basic principles of incentive systems in the context of reward cards in shops, or car insurance standards emphasizes again the consumerist, market-driven element of such initiatives, and it needs to be assessed whether or not the differing goals of these initiatives are compatible with goals such as improving population health or fairness in healthcare.

Conclusion

It must be admitted that the approach set out here is somewhat less clear-cut than one of the for-or-against personal responsibility stances often encountered in the literature and especially in political debates. With a number of different types of forward- and backward-looking responsibilities; a procedural justice account supplemented with seven tests to specify the areas in which justification is owed, without a single test whose outcome would necessarily “trump” all others, the situation seems to be messy. But I contend that this situation is still preferable to any of the alternative options, if we want to avoid the victim blaming potential that personal responsibility police typically have, and equally the potentially fatalistic implications of the social determinants of health approach, and instead seek to preserve a meaningful concept of health responsibility that is

appropriate in descriptive, epidemiological, and moral terms. Particular policies that seek to implement personal responsibility standards hence depend on a holistic justification in a number of different areas. These areas, as circumscribed by the seven tests outlined above, concern central values that are integral to the provision of healthcare, and I believe that much progress can be made in policy and practice if, in a transparent and open process, valid and explicit reasons, and sound evidence to support them, are given in the design and evaluation of personal responsibility policies.

References

- Arneson, R. (1997). Equality and equal opportunity for welfare. In L. P. Pojman and R. Westmoreland (Eds.), *Equality: Selected readings* (pp. 229–241). New York: Oxford University Press.
- Bishop, G., & Brodkey, A. C. (2006). Personal responsibility and physician responsibility – West Virginia’s Medicaid plan. *New England Journal of Medicine*, 355(8), 756–758.
- Braun, B., Reiners, H., Rosenwirth, M., & Schlette, S. (2006). *Anreize zur Verhaltenssteuerung im Gesundheitswesen*. Gütersloh: Bertelsmann Stiftung.
- Brown, A. (2005). If We Value Individual Responsibility, Which Policies Should We Favour? *Journal of Applied Philosophy*, 22(1), 23–44.
- CAF. (2008). Constitutional Advisory Forum to the Secretary of State for Health, *Report of the Constitutional Advisory Forum to the Secretary of State for Health*. London: Department of Health.
- Callahan, D. (1998). *False hopes: Overcoming the obstacles to a sustainable, affordable medicine*. Piscataway, NJ: Rutgers University Press.
- Cappelen, A. W., Norheim, O. F. (2005). Responsibility in health care: A liberal egalitarian approach. *Journal of Medical Ethics*, 31(8), 476–480.
- Chan, M. (2008). Statement at press conference of the launch of the Commission on Social Determinants of Health final report: *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva: Palais de Nations. Retrieved from http://www.who.int/social_determinants/final_report/en/index.html
- Commission on Social Determinants of Health (CSDH). (2008). *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva: WHO.

- Daniels, N. (2007). *Just health: Meeting health needs fairly*. Cambridge: Cambridge University Press.
- Daniels, N., & Sabin, J. (1999). Decisions about access to health care and accountability for reasonableness. *Journal of Urban Health*, 76(2), 176–191.
- Department of Health (DH). (2008). *The National Health Service Constitution – a draft for consultation*. London: Department of Health.
- Department of Health (DH). (2009). *The NHS Constitution for England*. London: Department of Health.
- Dworkin, G. (1981). Voluntary health risks and public policy. *Hastings Center Report*, 11(5), 26–31.
- Dworkin, R. (2000). *Sovereign virtue: The theory and practice of equality*. Cambridge, MA: Harvard University Press.
- Engelhardt, H. T. Jr. (1981). Human well-being and medicine: Some basic value-judgments in the medical sciences. In: T. A. Mappes & J. S. Zempaty (Eds.), *Biomedical Ethics* (pp. 213–222). New York: McGraw-Hill Book Company.
- Feiring, E. (2008). Lifestyle, responsibility and justice. *Journal of Medical Ethics*, 34(1), 33–36.
- Forde, I., & Raine, R. (2008). Placing the individual within a social determinants approach to health inequality. *Lancet*, 372, 1694–1696.
- Halpern, D., Beales, G., & Heathfield, A. (2004). *Personal responsibility and changing behaviour: the state of knowledge and its implications for public policy*. London: Cabinet Office.
- Heath, I. (2008). The emperor’s new constitution. *British Medical Journal*, 337, 787.
- Hilzenrath, D. (2010). Misleading claims about Safeway wellness incentives shape health-care bill. *Washington Post*, Sunday, January 17.
- Le Grand, J., & Srivastava, D. (2008). Economic incentives for long-term health gain – a report for Health England. Retrieved from www.healthengland.org/health_england_publications.htm
- Roemer, J. (1994). *Egalitarian perspectives*. Cambridge: Cambridge University Press.
- Roemer, J. (1995). Equality of opportunity. *Boston Review*, April–May.
- Scanlon T. (1998). *What we owe to each other*. Cambridge, MA: Belknap Press.
- Schmidt, H. (2008). Bonuses as incentives and rewards for health responsibility: a good thing? *Journal of Medicine and Philosophy*, 33, 198–220.
- Schmidt, H. (2009a). Just Health responsibility. *Journal of Medical Ethics*, 35(1), 21–26.

- Schmidt, H. (2009b). Personal responsibility in the NHS Constitution and the social determinants of health approach: competitive or complementary? *Health Economics, Policy and Law*, 3(2), 129–138.
- Schmidt, H., & Doran, T. (2010). Incentive use, equity and solidarity in Germany [manuscript under review].
- Schmidt, H., Stock, S., & Gerber, A. (2009). What can we learn from German health incentive schemes? *British Medical Journal*, 339, 725–728.
- Segall, S. (2007). In Solidarity with the Imprudent: A Defense of Luck-Egalitarianism. *Social Theory & Practice*, 33(2), 177–198.
- Stemplowska, Z. (2008). Making Justice Sensitive to Responsibility. *Political Studies*, 57(2), 237–259.
- Van Baal, P. H. M., Polder, J. J., de Wit, G. A., Hoogenveen, R. T., Feenstra, T. L., Boshuizen, H. C., Engelfriet, P. M., & Brouwer, W. B. F. (2008). Lifetime Medical Costs of Obesity: Prevention No Cure for Increasing Health Expenditure. *PLoS Medicine*, 5(2), e29.
- Wanless, D. (2004). *Securing Good Health for the Whole Population*. London: HM Treasury.
- Werner, M. H. (2002). Verantwortung. In M. Düwell, C. Hübenal, & M. H. Werner (Eds.), *Handbuch Ethik* (pp. 521–527). Stuttgart: J. B. Metzler.
- Wikler, D. (1987). Persuasion and coercion for health – ethical issues in government efforts to change lifestyles. *Millbank Memorial Fund Quarterly/Health and Society*, 56(3), 303–338.

Leadership and the Road to Personal Responsibility to Healthy Behavior – Between Autonomy and Paternalistic Interventions

Gil Siegal and Neomi Siegal

Introduction

Governments seem to be positioned in a most appropriate spot to lead, influence, and improve the health of the populace. Yet designing appropriate policies aimed at improving the public's health is a daunting mission. While the endpoints seem rather clear – for example, to improve individuals' health status, to assure access to needed health services, or guarantee an acceptable cost-benefit ratio for invested resources – the road there is rather bumpy, to say the least. Indeed, health policy leaders are facing growing pressures from numerous and sometimes conflicting sources. Such demands include, among others:

- a. Consumers' expectations for up-to-date, innovative, faultless, and accountable performances;
- b. Budgetary constraints in face of escalating costs due to the growing burden of chronic diseases, higher life expectancy, and expensive new technologies;
- c. A challenging undertaking in equipping today's workforce for contemporary and the prospective needs of complex healthcare systems.

In addition, policymaking is subject to tightened scrutiny on part of the media, the public, and legal institutions – by both the legislature and the courts. Clearly, society's tenets (for example, in Western liberal societies – liberalism and autonomy, democracy and egalitarianism, solidarity, or fairness) are expected to frame the issues and reflect in policymaking in every field, and health is no exception. Therefore, merely identifying an acceptable end (such as eradicating an infection, or