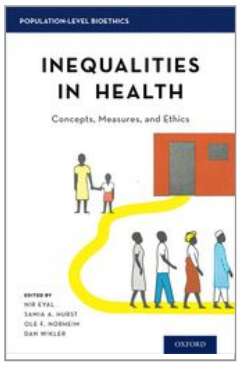

Inequalities in Health: Concepts, Measures, and Ethics
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Individual Responsibility, Health, and Health Care

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Abstract and Keywords

This chapter asks the question: what extent should people be held responsible for their health and therefore responsible for paying for their own health care? It argues that many of the causes of ill-health are beyond the control of individuals (especially less well-off ones), and therefore there is an argument for collective responsibility for meeting the costs of health care in such cases. Even in situations where the ill-heath is partly a result of the individual's choosing to engage in risky behaviour, such as smoking, the health outcome is partly determined by luck and partly by misjudgements, many of which it would be hard to blame on the individual herself. Hence there is a case for some form of collective responsibility for health care in these cases as well, perhaps in the form of taxing the risky behaviour and using the revenues thus raised to fund the relevant care.

Keywords: responsibility, health, health care, choice

Should individuals be held responsible for their own state of health? If they should be (or indeed if they should not be), should they be responsible for their own health care? What are the implications of the answers to these questions for the role of the state or, more generally, of the wider community? Should the state intervene to save people from the unhealthy consequences of their own actions? Should the state, or the wider community, pay for the health care of those who, through their own behavior, have contributed to their state of ill health? This chapter attempts to address these questions.

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Responsibility and Control

In the context of discussions concerning interpretations of equity or social justice, I have argued that judgments about the inequity or injustice of the situation that an individual find his- or herself in depends crucially on the extent to which his or her situation is the result of factors within or beyond his or her control (Le Grand 1984, 1991), a position taken up by other philosophers and now known as luck-egalitarianism (Arneson 1989; Cohen 1989). If the factors determining an individual's situation are entirely beyond his or her control, the situation may be judged inequitable; if they are completely under his or her control, then it can be judged equitable.

Although these arguments are phrased in terms of equity or social justice, similar ones can be made using the language of responsibility. Specifically, judgments about the extent of responsibility that an individual has for his or her situation depend on the extent to which his or her situation is the result of factors within or beyond his or her control. If the factors determining his **(p. 300)** or her situation are entirely beyond his or her control, then he or she is not responsible for that situation; if they are completely under his or her control, then she is completely responsible; if they are partly under his or her control, then he or she is responsible to the extent that they are under control.

If this conception of responsibility is accepted, then, applied to the question of health and, more specifically, to the question of paying for health care, it would imply the following. If an individual's health state depends on factors entirely within his or her control, then he or she is responsible for that state and hence for (paying for) any health care that she might need. The health care should be financed either through the taking out private insurance or through paying directly out of pocket. If, on the other hand, his or her health state has arisen entirely from factors beyond his or her control (an inherited disease, say), then he or she is not responsible, and there is a prima facie argument for his or her health care to be financed by the state or the wider community, funded through taxation or some form of social insurance scheme. If his or her health state has arisen partly from factors within her control and partly from factors beyond his or her control, then the answer is a mix of public and private insurance.

These arguments may be relatively straightforward in theory but present distinct problems for their application in practice. For that will depend on how easy it is to identify how much control the individual has over the factors that contribute to his or her health state. And this is actually far from easy.

The factors determining (or affecting) individuals' health states are often divided into five categories: genetic, social, environmental, behavioral, and (errors from) health care. So, for instance, a much-quoted estimate has put the proportional contribution of each of these to premature mortality (one measure of ill health) as: genetic 30 percent, social 15 percent, environment 5 percent, health care errors 10 percent, and behavior 40 percent (McGinnis, Williams-Russo, and Knickman 2002). Now, for some of these factors, the extent or lack of control that individuals have over them can be specified relatively easily. Individuals have no control over their genes; so, if an illness is entirely genetic in origin, the individual can in no way be held responsible for that. Similarly, there seems to be little argument for holding individuals responsible for ill health that arises from (the surprisingly large) proportion due to errors in their health care. Once in the hands of the health system, individuals usually have little control over the care they receive, and they certainly have little capacity to avoid any actual errors their medical practitioners may make. So, for at least two of the factors listed above—amounting to 40 percent of the contribution to premature mortality, if the figures above are accepted—the individual has no responsibility for the ill health that may derive from them.

It might seem at first as though similar arguments could be made about the social and environmental factors, especially for the less well off. Poor **(p.301)** individuals and families have fewer choices open to them than the better off. Many, perhaps most, poor individuals live in unhealthy environments, suffering from air and water pollution of various kinds; they also face high costs of, and have limited opportunity for, engaging in healthy activities, including good nutrition and exercise. If, as a consequence of these restricted choices, they fall ill, it would be hard to hold them responsible for that state.

However, things are not quite so simple. Are the restricted choices faced by the poor completely beyond their control? To what extent are the poor responsible for their very poverty? To what extent does their poverty arise from factors within their control or beyond their control? Not all the poor are victims of circumstance; some are in poverty as a result of their own choices and actions. Also, not all the poor are unhealthy: some manage to escape the constraints of their situation and engage in, for instance, good nutrition and exercise.

Which brings us to the vexed question of behavior. That certain behaviors do contribute to ill health is beyond dispute. For instance, it is well established that behavior involving the excessive consumption of tobacco, calories, salt, fat, and alcohol contribute not only to the principal fatal illnesses such as heart disease, malignant neoplasms, and cerebrovascular diseases, but also to many illnesses associated with high morbidity, such as diabetes and liver and kidney diseases (Detels et al. 2002). But is behavior of this kind—or of the other kinds that affect health or ill health—under individual control? And can we conclude from the indisputable fact that behavior matters for health that all individuals who, say,

drink, smoke, or eat too much are wholly responsible for their health states, and —by implication—responsible for (and therefore responsible for paying for) their health care?

I think not. This is for a number of reasons. Two are fairly obvious. First, it is clear from the preceding discussion that not all the factors that contribute to this behavior are under the control of the individuals concerned. Some obesity is undoubtedly genetic. Even a tendency to addictive behavior of the kind involved in excessive smoking, alcohol use, or drug consumption has been identified as possibly having genetic roots. Second, some of the behaviors concerned arise from social and environmental factors that are indeed beyond individual control. A preference for fattening food may come from dietary patterns established in childhood. More important, as we have seen, many of the poor face environmental constraints on their behavior over which they have little power, and, moreover, many (probably most) of the poor are actually poor for reasons that are largely beyond their control.

But there are two other, perhaps more subtle, reasons why individuals should not be held completely (or even largely) responsible for their health states even when these arise from their own “unhealthy” behavior. The first concerns the role of luck, the second, the possibility of misjudgments. These require more attention. **(p.302)**

Luck

First, the role of luck. Take the case of habitual smokers. Suppose that there is a 50 percent chance of heavy smokers developing lung cancer over their lifetimes from their habit. In that case, not every smoker will develop lung cancer; indeed, half will not. The half who do are the victims, not only of their own choices but also, at least in one sense, of bad luck. Their health in this situation is in part the outcome of a lottery and thus beyond their control—except in so far as they chose to enter that lottery in the first place. Thus, it would not seem fair to hold them *fully* responsible for their health state and hence for their health care—especially since half the smoking population will have made the same choices as them, but will face no cost at all: no ill health cost (at least not for that reason) and no cost of consequent health care.

Of course, the fact remains that the smokers concerned did choose to enter the lottery in the first place. So there does seem to be a case for their bearing some of the responsibility for their actions. But, in that case, perhaps there is also an argument for allocating a certain amount of responsibility to those who did not get lung cancer; for the (fortunate) outcome for them was also a matter of luck and thus beyond their control.[1] How might this be achieved?

One way is to consider the *ex ante* situation at the point at which the smoking “lottery” is entered and to invoke the concept of *annual expected value*. The annual expected value of an uncertain outcome is the value of the outcome itself

multiplied by the probability of it actually occurring in the year concerned. So, if, for instance, the expected costs of treatment for lung cancer are £50,000 and the chances of a smoker acquiring it in any one year is 5 percent, the expected value of those costs is £2,500. Now it seems reasonable to hold people responsible for the expected value of an uncertain outcome, whether or not the outcome actually occurs. In this situation, this could be achieved by compelling all smokers to take out an appropriate amount of private health insurance (in the—unlikely—event that the private health insurance market were perfectly competitive, the annual premium would actually be equal to the expected value: £2,500). Alternatively, a tax could be levied on the activity itself (a tax on tobacco), and the proceeds of the tax devoted to paying the treatment costs involved. In either case, smokers would bear a measure of responsibility for their actions—and the responsibility would be borne regardless of whether those actions had adverse consequences for their own health.

More generally, for activities in which health risks can be clearly identified, everyone who undertakes the relevant activities should bear the costs of the associated health care, either through compulsory private insurance or some form of hypthecated tax on the activity concerned. **(p.303)**

Misjudgments

What of individuals who make misjudgments in their behavioral decisions and, as a result, end up in an unhealthy state? People can make misjudgments with respect to healthy and unhealthy behaviors for a number of reasons, including poor information, myopia, and what Aristotle termed *akrasia* or modern philosophers “weakness of the will” (Dworkin 1981).

The problem of poor information arises when individuals do not know or misperceive the health risks involved in their behaviors. In such cases, it would not seem appropriate to hold them fully responsible for their behavior, and it would therefore be appropriate to require some state intervention. However, in this case, it would seem that the appropriate role for the state in such cases is not to pay for the health care consequent on the individual undertaking risky behavior but simply to provide the individuals concerned with the correct information; then they would then become responsible for their actions.

Myopia and akrasia provide a stronger case for state involvement in paying for health care. Myopia or short-sightedness arises because the costs of most unhealthy activities impact in the future, whereas the benefits from them occur in the present. So, for a 20-year-old, the smoking of a cigarette or the playing of a computer game now, instead of, say, taking exercise, has an immediate pay-off in terms of pleasurable sensations or relaxation, whereas the cancer or heart disease that may follow is probably at least 30 years away. Given that the future is uncertain, it is then perfectly rational for the individual concerned to

“discount” those costs: that is, to place a lower weight on them than if they were to occur in the present.

There are a variety of sources of this uncertainty and thus of discounting. He or she may die of something else in the meantime; there may be medical advances that mean that cancer or heart disease will not be the killers that they are now. Moreover, as we have seen, there is the question of his or her own physiognomy: many smokers or heavy eaters do not contract lung or heart disease, and the individual concerned may be one of the lucky ones.

Another reason for discounting the future is the phenomenon that, even in a world where there is certainty, people often seem to prefer pleasure now to that in the future. As David Hume says, “There is no quality in human nature which causes more fatal errors in our conduct than that which leads us to prefer whatever is present to the distant and remote (Hume n.d.).”

Now, even if the phenomenon of myopia is regarded as leading to “fatal errors” or mistakes, it is understandable. Most individuals find it difficult to conceive of being 30 years older than their current age: 20-year-olds may perceive themselves as being different people from their 50-year-old selves, in so far as they think about them at all, and hence thus may not weight these “other,” rather alien, people’s interests as much as their own immediate ones. **(p.304)**

Indeed, there may be a form of “external cost” here, in which an individual engages in an action in which a third party (her older self) is affected adversely, but in which that third party is in no position to influence the activity or avoid its effects. In this case, the individual concerned, in deciding on her actions, does not give the consequences for her older self the same weight as that older self would if she were present. Hence, she may engage in actions that will damage that older self, creating what economist call an *externality*, a form of market failure that is often used to make a prima facie case for state intervention (Le Grand 2006, pp. 88–91).

Then there is akrasia or weakness of the will. Anecdotally, people undertaking unhealthy activities often acknowledge they are not necessarily acting in their own best long-run interest. The individual’s “long-run self”—the person looking months in advance or reflecting on the experience in retrospect—admits to foolishness. And there is broader evidence for this phenomenon from public surveys. For instance, the desire to give up smoking is perhaps the most commonly reported anecdote supporting a long-run preference being unrealized as a result of weakness of the will at the point at which having another cigarette must be resisted. And surveys conducted by the U.K. Office of National Statistics have consistently reported that around 70 percent of current smokers in Great Britain wish to give up smoking (Taylor et al. 2006).

Telling evidence on the overall prevalence of misjudgment in smoking behavior comes for a study on smokers' reported levels of welfare. This measured the effect of various levels of cigarette taxes, using demographic and survey data. It examined whether increasing the price of cigarettes, and thus making them less attractive, led people whose demographic factors predicted them to be smokers to be any happier than comparable people in areas where excise duties were lower. The results showed significant and quite substantially higher rates of happiness following tax increases, in two quite independent datasets from the United States and Canada (Gruber and Mullainathan 2005). This suggests that smokers making a decision to smoke are misjudging what brings them a higher level of well-being; that they would have greater happiness if they were forced or in some way encouraged to restrict their smoking.

So where does this leave us with respect to responsibility, especially with respect to paying for health care? Since it is apparent that individuals do make misjudgments over decisions with respect to their longer run selves, and these misjudgments are understandable and indeed not necessarily avoidable by a reasonable person, it seems inappropriate to hold them fully responsible for the outcomes of the misjudgment. Again, therefore, we are pushed in the direction of the state, not the individual, meeting the relevant costs. **(p.305)**

Conclusion

It may seem surprising that, starting from what might be thought of as an individualistic or desert-based notion of responsibility, we have developed a number of arguments that support a collectivist notion of financing health care, with the state meeting much of the relevant costs of ill health or intervening in other ways to save people from the consequences of their unhealthy decisions. So it is worth recapitulating the relevant arguments.

We started from the position that the degree of responsibility that individuals have for their health depends on the extent to which they have control over the factors that affect their health. We pointed out that many of those factors are actually beyond most individuals' span of control and that, for other factors, it is not easy to identify what is under their control and what is not. Moreover, even when an element of control can be identified, there are still health outcomes that arise from bad luck or from the understandable, and not easily avoidable, misjudgments that individuals make. Hence it is difficult, indeed impossible, to claim that individuals can be demonstrated to be wholly or even largely responsible for their health and therefore for paying for their own health care. Hence this suggests that a largely collectivist health care system is appropriate —at least in terms of finance.

Of course, issues concerning individual responsibility are not the only arguments concerning the appropriate role of the state with respect to health and health care. In particular, there are a number of well-known reasons why private

markets in the area can fail to achieve social efficiency, including the presence of externalities, asymmetric information between patient and medical provider, and, in private health care insurance markets, the problems of moral hazard and adverse selection. Such arguments usually point in the direction of the desirability of some form of state intervention in that area. What the arguments of this chapter suggest is that this conclusion can be buttressed by arguments concerning the extent of individual responsibility.

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Notes:

(1) Earlier versions of this argument can be found in Le Grand (1991, chapter 7).