

Individual Responsibility, Justice and Access to Health Care

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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Abstract

The aim of this thesis is to examine whether it is morally defensible to use lifestyle as one of the criteria for rationing health care. I argue that it is not justifiable to use former lifestyle to select patients for treatment.

Chapter one outlines the principles of the NHS and discusses the reality of rationing in health care provision in Britain. I maintain that there is a *prima facie* legal and moral right to health care and explore whether this right imposes a responsibility on individuals to maintain a healthy lifestyle.

Chapter two critically examines some of the criteria, which are used to ration health care. Government policy documents, such as '*The New NHS: Modern. Dependable.*' (Department of Health 1997: 13) suggest that patients should be treated 'according to need and need alone.' I argue that the concept of medical need is indeed one of the proper criteria for the distribution of medical resources. However, it is not the only relevant criterion and should be considered along with other factors such as patient choice, clinical and cost effectiveness. Other criteria including age and lifestyle may also be relevant, but in so far as they affect the probable clinical outcomes of treatment.

Chapter three clarifies some of the contemporary approaches to distributive justice and explores their implications for the allocation of health care between individuals. I suggest that an eclectic approach should be adopted where consideration is given both to promoting individual choices about lifestyles and protecting the welfare of the community. None of these theories of justice suggest that taking lifestyle into account when allocating scarce resources must be unjust.

Chapter four investigates whether individuals should be held responsible for their lifestyle. I argue that some health related behaviour is voluntary and therefore people might be held responsible for the consequences of their behaviour. However, in many cases health related behaviour may not be voluntary, because it may have been unduly influenced by factors beyond the control of the individual. Even if it is voluntary, it may be justifiable or excusable in some cases. I discuss whether risk takers deserve any blame, and maintain that withdrawal or delay of medical treatment as a punishment for former lifestyle is always wrong.

Chapter five argues that it is essential for health care professionals to inform people of risks to their health. This does not interfere with their liberty, and allows them to make choices based upon their own values. I also examine whether it is justifiable to use more coercive strategies, such as persuasion, manipulation and legal prohibition in order to encourage people to maintain a healthy lifestyle.

Chapter six argues that it is not possible to implement a policy to ration health care partly on the basis of lifestyle in a fair way. I propose an alternative policy, which involves taxation on certain products associated with risk. Chapter seven examines a variety of cases of rationing based on lifestyle. I conclude that rationing according to former lifestyle is not morally defensible.

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Chapter One

THE NATIONAL HEALTH SERVICE: PRINCIPLES AND REALITY

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1.1 The Principles of the National Health Service

The National Health Service in Britain offers medical care to the entire population - a 'comprehensive' service designed to restore, protect and improve the health of the nation. According to The National Health Service Bill (1946), all the services, or any part of it, should be available to every citizen in England and Wales, regardless of ability to pay, age, sex, employment or vocation, area of residence, or insurance qualification (HMSO 1946). The original Bill implies that there are no limitations on availability. Certainly, there is no suggestion that individuals might forfeit health care, if they adopt certain unhealthy lifestyles, or indulge in high-risk activities.

Indeed, Aneurin Bevan, the founder of the NHS stated that 'medical treatment and care should be made available to rich and poor alike in accordance with medical need and by no other criteria' (Ham 1981: 23). Subsequent governments have reaffirmed these principles. The Patients' Charter emphasizes that the government believes there must be no change to the fundamental principles on which the NHS was founded, and that it should be financed primarily from general taxation (DOH 1992: 4). The White Paper (1997: 13), '*The New NHS. Modern. Dependable.*' also states that patients in the NHS will be treated 'according to need and need alone.'¹

Nevertheless, the British Medical Association (BMA 2001) states that some form of rationing is and always has been, inevitable. This report suggests that while public support for the principles of the NHS remains strong, there is an increasing awareness of the difficulties in delivery. Indeed, the review concludes that the concept of the NHS, as a comprehensive service may have outlived its usefulness, and that treatments which are judged to be of limited clinical effectiveness, or not cost effective, will increasingly be excluded from provision. Even if there is an increase in funding, as proposed in '*The NHS Plan*' (Department of Health 2000), it appears that rationing of

¹ The concept of need will be discussed in Chapter 2.2

health care is a necessity.

In this introductory chapter, I will consider how the objectives of the National Health Service have been implemented in practice and review current health care provision in order to determine if the NHS has achieved these objectives in reality. I will clarify and contrast the terms, 'rationing' and 'priority setting', and discuss some of the various mechanisms of rationing. I will describe some recent examples of rationing in health care and discuss whether rationing is inevitable in the future. Finally in this chapter, I will comment on the notion of a right to health care, and make some preliminary points about the idea that individuals have a responsibility to maintain their health.

The Royal Commission on the National Health Service was appointed in 1976 to review the entire service and to determine the best use and management of the financial and manpower resources. Their report (1979: 9) presents the objectives underpinning the NHS as follows:

- 'Encourage and assist individuals to remain healthy;
- Provide equality of entitlement to health services;
- Provide a broad range of services of a high standard;
- Provide equality of access to these services;
- Provide a service free at the time of use;
- Satisfy the reasonable expectations of its users;
- Remain a national service responsive to local needs.'

Some of these objectives are controversial, lack precision, and may in some cases be unattainable. For example, it is not clear how strenuously health care professionals should assist individuals to remain healthy. What responsibility does the professional have if the patient chooses to partake in activities, which are a known risk to health? Secondly, there is no guarantee that individuals will be given the health care that they

seek, if only 'reasonable expectations' will be satisfied. What are reasonable expectations given that resources are finite?

Nevertheless, these objectives confirm the principles that there should be equity in the distribution and use of health care, and that the service should be 'free at the time of use' for patients. However, the individual who pays for eye checks, dental care and prescription charges may question whether health care is really free at the time of need.

The National Health Service and Community Care Act (1990) introduced the concept of the 'internal market' for health - separating the buyers (in the form of District Health Authorities and G.P. fund holders) and sellers (in the form of hospitals). This separation made decisions about funding, and the provision of services, more explicit and amenable to public scrutiny and there was correspondingly a raised awareness about the provision, or perhaps more importantly the lack of provision, of health care.

The 1990 Act did not change the legal obligations imposed by the National Health Service Act 1977. The Secretary of State still has a duty to continue the promotion of a 'comprehensive health service' 'to such extent as he considers necessary to meet all reasonable requirements' (Newdick 1993: 54). The precise meaning of 'all reasonable requirements,' as determined by the Secretary of State, remains controversial. A number of well-publicized cases, where patients have sought treatment on the NHS and have been denied their demands, have illustrated the potential conflict and differing perceptions about what should be classified as a health care need.²

² Weale S. 'Age blow to childless seeking IVF.' *The Guardian* October 18, 1994. This article describes the case of Julie Seale who was denied in vitro treatment on the NHS because she was deemed to be too old at 36. Also see Redmayne S. Klein R. 'Rationing in practice: the case of in vitro fertilisation.' *British Medical Journal* 1993, 306, 1521-4. Also see Entwistle V.A. Watt I.S. Bradbury R. Pehl L.J. 'Media coverage of the Child B case.' *British Medical Journal* 1996, 312, 1587-1591.

The concept of rationing was not apparent in the original White Paper of 1944, rather the reverse: 'the proposed service must be comprehensive in two senses - first that it is available to all people and second, that it covers all necessary forms of health care' (CMD6502 1944: 9). Nevertheless, the Royal Commission (1979) recognizes the impossibility of meeting 'all' demands for health care and has accordingly modified its stated objectives to provide a 'broad range of services.' Health promotion, disease prevention, cure, care and after care would be included. However, the Report acknowledges that the financial resources available to the NHS are finite and there is a need to set priorities for the allocation of health care resources. 'It is misleading to pretend that the NHS can meet all expectations. Hard choices have to be made. It is a prime duty of those concerned in the provision of health care to make it clear to the rest of us what we can reasonably expect' (CMND 7615 1979: 11).

While the Royal Commission of 1979 acknowledges the need to set priorities in health care provision, there appears to be a reluctance to accept the notion of rationing. Politicians tend to avoid discussions about the reality of rationing and prefer to talk about setting priorities in health care (Bottomly 1994: 338; Milburn A. 1997). Regardless of the adopted terminology, the difficulty of making choices about who should be treated in health care is well recognized:- 'Unfortunately there is no universally acceptable method of apportioning the limited health resources available to the NHS between different possible users and services' (*Royal Commission on the National Health Service CMND 7615 1979: 52*).

The explicit acknowledgment of priority setting or rationing in health care would represent a fundamental change in the principles of the NHS. However, the principles of the NHS do not suggest that patients have the right to any specific treatments on the NHS. Rather it appears that politicians, managers and doctors can decide which treatment (if any) is offered to the patient, within the constraints of the available

resources. While there is no recognition of rationing in any form within the recent government policy documents, and some politicians deny that rationing exists, the reality of practice and the experience of both health care professionals and their patients may be very different.

1.2 Rationing and Priority Setting

According to Klein, Day and Redmayne (1996: 7), 'rationing' is a word, which conveys a sense of proportionality – dividing scarce resources in a fair way so that everyone receives what is deemed to be their share. This notion of rationing was evident in the Second World War when limited supplies were rationed in Britain to promote the equitable distribution of food in order to meet everyone's basic nutritional needs. Rationing can take place in any situation where there is demand and a corresponding scarcity of resources so that decisions about distribution have to be made. Health care, higher education, housing and welfare services are all subject to current rationing in the United Kingdom.

Rationing in the health service is said to involve 'the denial or dilution of something that is potentially beneficial to the patient: he or she is getting less in the way of treatment than might be thought desirable in a world with unlimited resources.' (Klein, Day and Redmayne 1995: 770). Rationing takes place in circumstances where provision is constrained by considerations of cost and /or limited facilities such as specialist staff, diagnostic equipment, operating theatres or organs for transplantation.

Priority setting, a phrase often adopted by politicians (Bottomley 1994: 338), implies that services are available for everyone, but some will be treated before others. The idea of prioritization is not new and both in wartime conditions, and in major accidents, triage is operated as a form of priority setting. Resources may be diverted towards those most likely to survive, those in immediate danger, and those who may be able to assist others. Virginia Bottomley (1994: 338) states that the government has a legitimate role to play in setting priorities for the health service, but denies that rationing is a reality: 'As everyone is covered by a universal and freely available health service the problem is one of setting priorities rather than sharing out resources.'

However, the distinction between rationing and priority setting may be blurred since a particular treatment may be given such a low priority, that in reality it means that nobody will receive the treatment, and it is in effect withdrawn. Alternately, patients may be placed on a waiting list, which is so long that in practice they will never reach the top and in effect treatment is denied at the time of need.

Klein et al (1996:7) suggest that the term 'rationing' should be reserved to describe 'the process by which resources are allocated to individuals at the point of service or programme delivery.' This notion is distinguished from 'priority setting' which is used to describe the process of setting the budgets for specific services at government or departmental level. This contrast is sometimes made by reference to microallocation and macroallocation of resources (Daniels 1985:1), where decisions at the macro level determine what kinds of health care services will be provided, who will deliver them and how they will be financed. It is misleading to draw a sharp dividing line between macro and micro levels of decision making, because professionals making choices about which patients should be treated, (microallocation), are obviously influenced by the overall institutional policies and macroallocation of resources.

In this thesis, I will adopt the term 'rationing' because I shall be concerned mainly with decisions about which individual should be treated, when it is not possible to treat everyone, with the treatment of first choice, because of limited resources. In essence, I am concerned with the micro allocation of health care resources and those decisions made by health care professionals about which patient is given scarce resources. I will explore whether it would be justifiable to allocate, or withdraw, health care to a particular patient partly on the basis of his or her previous lifestyle.

There are various forms of rationing evident in practice. Health care provision can be rationed by delay, as in the case of waiting lists, or by denial, as in the case of refusing

treatment - such as removal of tattoos, or surgery for varicose veins. Individuals can be refused treatment, because of their age or lifestyle, either explicitly, or implicitly - when doctors refer patients to other agencies, such as social services. Alternately, people can be deterred by delays in seeing the doctor of their choice, by waiting times at clinics, or by difficult journeys.

As already noted, (page 4 footnote 2), rationing may occur by excluding particular treatments, or refusing to treat certain medical conditions. This form of rationing has been tried and tested in the American State of Oregon, where medical services available on Medicaid are rationed according to a formula, which takes account of the public perceptions of the relative worth of each treatment (Dixon Gilbert Welch 1991: 891). If a treatment is below the so-called 'funding line' it is simply not offered on Medicaid. Such a policy does not discriminate between identified individuals and does not explicitly make judgements about the worth, lifestyle or desert of any particular person. However some of the Oregon preferences do seem to reflect popular antipathy for the undeserving ill such as alcoholics and the promiscuous.

While these examples of rationing restrict access to services, rationing can also take place by 'dilution' where a poor quality of service is offered. For example, the number of qualified staff is reduced, the environment is poor, the number of investigations is limited,³ and the quality of care does not reach an acceptable standard for either staff or patients. Such conditions have sometimes been evident in the so-called Cinderella services for the long-term elderly and those with learning disabilities, mental illness and physical disability. Klein (1998) suggests that dilution of services may be the most prevalent form of rationing. Patients can be prevailed on to accept alternative forms of

³ Hanratty et al (2000) found that women admitted to hospital for acute myocardial infarction would be recommended for fewer investigations than men who have heart attacks and were less likely to be given the most effective drugs. The authors suggest that the reason is that women who have heart attacks tend to be older than men who are treated for similar conditions. Nevertheless, the difference in age does not justify withholding of appropriate diagnostic tests and treatment.

treatment rather than their preferred option, and doctors can prescribe second choice drugs in order to reduce expenditure, and use the best only if they fail (Newdick 1995: 278). For example, people with schizophrenia could be denied modern drugs as a first line treatment, unless they have already suffered unacceptable side effects or failed to respond to traditional therapies (Donnelly 1999: 8).

Other distinctions between methods of rationing should be noted. There is a difference between allowing only certain people to gain access to medical care as compared to the scenario where everyone is offered a limited amount of medical care. This may be illustrated by analogy to alternative car parking policies. The policy may allow certain people, for example, only employees of the firm, to park, or it may allow anyone to park, but only for a limited time. This distinction may not always be relevant in health care provision because medical treatment does not come in easily divisible units; If cardiac surgery is proposed, it makes no sense to suggest the patient is not entitled to blood transfusions or an intensive care bed for more than two days. But for women who are receiving infertility treatment, it is possible to allow everyone access but only for two attempts at IVF or GIFT.

1.3 Examples of rationing in practice

While we may be reluctant to implement any rationing in health care, it appears to be a reality in the NHS. The British Medical Association (1993: 299) states unequivocally: 'In practice rationing of health care has always existed within the NHS, although rationing decisions have frequently not been taken openly.' All health care professionals are involved in decisions about resource allocation, because 'resources' are not just a matter of limited budgets, but include the allocation of time, skills and other medical facilities, such as specialist equipment and beds.

For example, the individual practitioner must decide on competing demands for health education, psychological support, physical care and giving information regarding the possible treatment options. Most people working in the NHS will recognize, (and complain bitterly) that their time is limited, so that they must identify priorities and make choices between the various therapeutic roles, skills and possible interventions; and further, between different patients.

If a nurse decides to spend half an hour talking with bereaved relatives this may result in delaying or sacrificing a teaching session about a healthy diet for another patient. Doctors who allocate an intensive care bed or operating theatre to one patient know that this may mean that the treatment for another will be delayed or denied altogether. Hence, all health care professionals take decisions concerning resource allocation and rationing.

There are several anecdotal accounts and reports in the media, which suggest that patients are not offered treatment on the NHS, which they desire and which might be beneficial for them, because of limited resources. In March 1995, there was

widespread media coverage concerning Child B (Jaymee Bowen)⁴ who was denied further treatment for leukaemia by Huntingdon Health Authority. Patients who are in severe pain and have to wait for several months on the waiting lists for hip replacement operations, and people with multiple sclerosis who are not prescribed interferon beta (Dyer 1997), may know that rationing of health care provision is a reality.

There is also anecdotal evidence that rationing according to age is practiced in the NHS. Whitfield (1999: 10) suggests that in-vitro fertilization is funded according to age, with one health authority restricting funding to those aged 35, no older and no younger. Old age is also cited as a criterion for rationing. Elderly patients may be admitted to general medical wards rather than coronary care units following cardiac problems. This may be a form of rationing by dilution, where an inferior service is offered to some patients. There are also suggestions that surgery may be delayed or even denied for elderly patients (Dinsale 1996).

Age Concern state that one in twenty people over the age of 65 have been refused treatment by the NHS, and in a survey conducted for the charity, many people suggested that they had noticed that their treatment was different following their 50th birthday (Beecham 1999: 1095). Bowling (1999: 1353) presents evidence that there is widespread ageism in cardiology with older patients receiving fewer life enhancing investigations and interventions than the younger population. Young Robinson and Dickinson (1998) present evidence that rehabilitation for older people is disorganized and inadequate despite clear guidelines about best practice. Grimley Evans (1997: 115) states that older people are discriminated against in the NHS and continue to be offered inadequate or second-rate treatment simply because they are old. New and Le Grand (1996) also describe a case where a 73-year old man was denied physiotherapy because he was over 65.

⁴ See Entwistle V.A. Watt I.S. Bradbury R. and Pehl L.J. Media coverage of the Child B case *British Medical Journal* 1996, 312: 1587-91

In addition, despite the claim that the NHS offers equality of geographical access, it is well documented that there are wide variations in the availability of services in the different geographical regions and trusts, which is unrelated to the differing needs of the population. Some health authorities have identified particular services, which they will not purchase, including GIFT and IVF for infertility (Redmayne Klein 1993: 1521). Treatments such as tattoo removal, reversal of sterilization / vasectomy, cosmetic surgery, and gender reassignment surgery have been removed from NHS provision in a few areas (BMA 1995: 8). These are clearly examples of denying particular services on the NHS, even though patients may demand such treatments, and indeed might benefit from them.

The government recognizes that there are major variations in health services between different areas: for example the level of cervical screening, and mortality from carcinoma of the colon show substantial differences between health authorities (Department of Health 1997). In addition, Bellis, McVeigh and Thomson (1999) have shown that the chances of dying from AIDS depends largely on where the patient lives, as funding per person treated varies significantly. It follows that the availability of treatments varies and this has an impact on the morbidity and ultimately the mortality of patients.

Other health authorities avoid explicit rationing by denial or exclusion, preferring to adopt a vague and less controversial form of rationing where certain services and procedures would be given a low priority in resource allocation. Within the limited budget, clinicians can decide whom to treat, and how and when to treat, according to their own criteria. Such criteria may not be made explicit, and may be concealed by the suggestion that treatment is 'not clinically indicated' for the patient (Hope, Sprigings and Crisp 1993: 379). Public discussion about the problems associated with limited funds and resources can therefore be avoided.

1.4 Is rationing of health care inevitable?

Prior to any discussion about the just criteria for distinguishing between individuals, in the allocation of scarce health care resources, we should ask if rationing in the NHS is inevitable? Will resources for health care provision always be limited, and will demand continue to rise? Perhaps it would be possible to increase the budget for health care, or manage a more efficient service, so that people could be treated according to their needs and demands?

I will suggest that rationing in the NHS is inevitable. Even if an increased proportion of the government's budget is allocated to the NHS, it would still be necessary to refuse certain treatments to some patients, treatments from which they might benefit. This does not mean that rationing is desirable, but I will argue that the demand for health care will continue to rise, despite a more efficient service, and a more effective health education and promotion programme, which may improve the general health of the nation. Secondly, I will argue that resources available for the NHS will always be restricted, however efficient the service and whatever the financial economy of the country.

Rationing has been evident since the formation of the NHS, and was clearly acknowledged by the Royal Commission on the National Health Service (1979: 51) 'The demand for health care is always likely to outstrip supply and the capacity of health services to absorb resources is almost unlimited. Choices have therefore to be made about the use of available funds and priorities have to be set.' The Royal College of Physicians (1995: iv) are in agreement that not all public expectations can be met within the NHS so that choices will have to be made.

Klein (1989: 182) predicts 'with absolute confidence' that the NHS will continue to

generate more demands on the political economy. He writes: 'Even if the limitations of medical technology in curing disease and disability are now becoming apparent, there are no such limitations on the scope of health services for providing care for those who cannot be cured. Even if policies of prevention and social engineering were to be successfully introduced, their very success in extending life expectancy would create new demands for alleviating the chronic degenerative diseases of old age. In short, no policy can ensure that people will drop dead painlessly at the age of 80, not having troubled the health services previously.'

This presents a peculiar irony in that the very success of medicine to prolong life expectancy results in a greater demand for services and associated increased costs to meet those demands. Simply expressed - when people live longer they require more health care because there is a higher incidence of chronic disease in old age. Chronic illness is not susceptible to cure, but demands on going care and support, with associated financial costs. While the maximum human life span has not changed significantly - people do not live much after 100 years - there is a notable increase in the average life expectancy of both men and women in the developed countries. The demographic change resulting from an ageing population has undoubtedly been a major cause in the increased demand for health care this century. Population projections for the future suggest that an increasing elderly population (Khaw 1999) will compound this issue.

The rise in demand for health care also results from a greater public awareness of possible medical treatments. The NHS was founded prior to the development of highly sophisticated technical care such as life support machines, renal dialysis or transplantation and there are now a variety of treatment options for many conditions. New and expensive drugs, such as A.Z.T. and other immunosuppressive drugs, both for preventative medicine and treatment, have been marketed and beneficial results are

widely proclaimed by the media. Public expectation has changed accordingly; Mason and McCall Smith (1994: 248) claim that the choice of treatment is increasingly influenced by patient's demands with a proportionate erosion of the doctor's clinical discretion.

In addition, health care needs are not static, but evolve as new technology and environmental factors develop. The expectations of the public, and the demand for new forms of treatment and drugs are increasing. Disease itself changes as illustrated by the development of AIDS and variant Creutzfeldt-Jakob disease. Dubos (1968: 75) states: 'It is a dangerous error to believe that diseases and suffering can be wiped out altogether by raising still further standards of living, increasing our mastery of the environment and developing new therapeutic procedures. The less pleasant reality is that, since the world is ever changing, each period and each type of civilization will continue to have its burden of disease created by the unavoidable failure of biological and social adaptation to counter new environmental threats.'

Increasing demands and costs in the NHS are reflected in the available international data. Brody (1992: 10-11) provides evidence from the OECD (Organisation for Economic Co-operation and Development) to show there has been substantial growth in health care expenditure throughout all of the developed countries during the last twenty-five years.⁵ This rise has happened independently of whether the country has had a privately owned health care system, or primarily government owned system, such as the British NHS. In response, a number of countries, including the Netherlands, Scandinavia, New Zealand, Sweden and Israel have discussed explicit

⁵ Doyal (1995: 281-282) questions whether the demand for healthcare resources really will continue to increase. He suggests that if steps are taken to minimise waste and rule out the provision of futile treatment, then predicted demand may not increase. In addition, he suggests that extra funding for health care could be found by increasing the allocated percentage of the gross national product and consequently a greater proportion of needs could be met. Nevertheless, he states that in the real world there is likely to be a significant gap between funding and resources to meet medical need. He concludes that rationing in health care is therefore inevitable.

policy options for rationing of health care resources.⁶

In summary, it appears that the demand for health care will continue to rise, and yet resources are finite and there will always be a limit to the provision of health care, both financially, and in respect to available skills, qualified staff and resources such as organs for transplantation. It is important to recognize that the NHS has to compete with other public sector services for its share of available funds. Those who claim that the budget for health should be increased according to demand, because health is a 'basic need,' must accept such a decision will inevitably lead to a reduced budget for such services as education, housing and social services. These services also meet the 'basic needs' of the population, and undoubtedly affect the health of individuals.

It is stating the obvious to say that good health and the absence of disease do not depend solely on the health service. Rather it appears that good health will depend upon a variety of factors such as environmental conditions, housing, relevant education and the promotion and availability of a healthy diet and lifestyle. Hospitals and the acute health services are only required as a last resort when the individual is no longer healthy. Indeed the majority of determinants of health such as lifestyle, genetic makeup, social and environmental conditions are not influenced by interventions currently available from the acute sector of the NHS.

It is relevant to note that perhaps the greatest influences on the health of the nation have arisen from policy changes outside the NHS. For example: The 1848 Public Health Act introduced the provision of adequate water supplies and sewerage systems, which resulted in a dramatic reduction of infectious diseases, such as cholera and typhoid, at a time when the medical profession were virtually powerless to intervene (Ham 1992: 7). The Chief Medical Officer, Kenneth Calman (1994: 71) states that the

⁶ Coulter and Ham (2000) discuss these options. Holm (1998) describes the process of rationing in Scandinavia. Chinitz, Shalev, Galai and Israeli (1998) discuss the policy in Israel.

funding of utilities such as transport, police, education and the environment may have a more important impact on health than spending on health care. The financial allocation of resources to health must, therefore, be considered in the light of the competing claims between various sectors of public expenditure.

In conclusion, the resources available for the NHS will always be restricted since there must be a balance between the various competing needs of the community, including education, housing, transport and sport. The obligation by the government to provide health care must, therefore, be seen within the context of other basic rights, obligations and values (Brody 1992: 14). It remains an essentially political decision to determine what share of the national resources should be allocated to health care, but there will always be a gap between the demands for health care and the available resources, and hence there will always be rationing.

1.5 The Right to health care

Legal rights are justified claims based upon the principles and rules established in the prevailing legal system. If the law changes then the associated legal rights will change accordingly. The Human Rights Act came into full effect on October 2, 2000 throughout the United Kingdom, and states that all courts must give effect to the provisions of the European Convention of Human Rights. This means that for the first time, British people will have the right to enforce a range of civil and political rights in their own courts, rather than having to present their cases to the European Court of Human Rights in Strasbourg. Among the rights included are the right to life, respect for private and family life, and the right to freedom from inhuman and degrading treatment. Dyer (1998: 1339) states that 'implementation of the act is certain to bring issues of NHS resources and healthcare rationing to the fore.' For example, it is possible that patients who are denied treatment on the basis of cost may invoke right to life arguments.

However the 'right to health care' has not been recognized by the legal system in this country, since legal rights to health care within the NHS usually take the form of general statutory duties, rather than individual entitlements. The National Health Services Act, 1977, Section 1 (1) states that: 'It is the Secretary of State's duty to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement -

- (a) in the physical and mental health of the people of those countries and
- (b) in the prevention, diagnosis and treatment of illness, and to provide or secure the effective provision of services in accordance with this Act.'

The Act, Section 3 (1), further implies that the Minister has a duty to provide services to such an extent, as he considers necessary to meet all reasonable requirements. The

Act does not, therefore, establish an absolute right to health care for individuals according to their perceived requirements. This has been confirmed in the courts where judges have upheld the decision of certain trusts / health authorities not to treat patients according to their demands or their parents' demands.⁷

People in England and Wales do have a legal right to the provision of 'free' health care (more accurately described as taxation financed), but the precise nature and level of this entitlement is indeterminate.⁸ This right implies a duty on some agency of the government to act, namely the NHS, rather than a duty on any particular individual. In other words, the legal right to health care is a claim right⁹ against the state rather than a right against fellow citizens. An unconditional right to health care does not exist because health care professionals decide which treatments are effective and which will meet the clinical needs of patients. According to current legislation in England and Wales, there is no individual right to a specific procedure, or to its delivery at a stated time and / or place (Dyer 1987: 1554).

'The Patient's Charter' (Department of Health 1991) sets out the rights and standards that everyone in Britain can expect from the NHS. These include the right 'to receive health care on the basis of clinical need, regardless of the ability to pay; to be registered with a GP; and to receive emergency medical care at any time,' amongst a total of seven existing rights and three new rights. Montgomery (1997: 60) states that this Charter does not create legally enforceable rights, but that they may be enforceable where they are already recognised in law. However, *'The Patient's Charter'* (1991:

⁷ For example see the case of Jaymee Bowen in Entwistle et al (1996)

⁸ Newdick (1993) discusses the legal rights of patients following the National Health Services and Community Care Act 1990.

⁹ Lockwood (1981: 150) adopts the terminology of claim rights and liberties: a claim right imposes an obligation on others to behave in certain ways and provide a 'service'. In contrast, liberty rights imply that individuals have the freedom to act in certain ways if they choose and others should refrain from interference. The supposed right to freedom of speech is a liberty right: individuals can normally express their views and others should allow them to do so. (There is no obligation on others to listen.)

19) requires all health authorities to publish information about their performance in relation to these rights and standards, and establishes a procedure for complaints, if individuals feel that they are being denied any of their Charter rights.

The notion of some kind of legal right to health care is a relatively recent concept, which has only become a practical reality in the United Kingdom with the creation of the NHS. This service was established at a time in the history of medicine when great achievements had been recognised: antibiotics and infection control had made a significant difference to both the quality of life and the expected quantity of life. There was no anticipation of the acute and highly specialised care with the associated soaring costs, which have subsequently been developed. Hence the NHS was created at a time when beneficial outcomes could be achieved at reasonable cost and it was feasible to think of a legal right to health care, which could be met at an affordable cost to society as a whole.

With the ongoing progress in medical technology and pharmacology and the current developments in genetics, the concept of a legal right to health care has become increasingly problematic. In the light of medical knowledge today, the right to health care must be restricted to a certain standard. It then becomes necessary to determine what is an acceptable standard of health care provision - a question that continues to challenge political and philosophical thinkers.

In practice, the extent that a legal right to health care can be honoured will depend upon the prevailing political priorities and the economic wealth of the community. I have argued that rationing is inevitable in the NHS, and that it will not be possible to provide for the needs and desires of everyone. If the government or designated institutions (the Department of Health and the NHS) are *unable* to provide all the

health care that individuals need, because of limited resources, we cannot say that they *ought* to do so.

The extent of the legal right to health care is further confused by the ambiguity of the term 'health'. Health is an exceedingly broad concept, which is notoriously difficult to define.¹⁰ Health care may be primarily concerned with the adequate functioning of the human body: preventing disease, diagnosing illness and providing treatment if needed. (This might be labelled as the bio-medical model.) However, this approach can be contrasted with a more expansive and idealistic concept of health which is reflected in the World Health Organisation definition of health: 'a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity' (WHO 1946).¹¹

While the treatment of cardiac angina, broken bones or infectious diseases is obviously classified as meeting health care needs within a medical model, it is less obvious as to whether preventative medicine, cosmetic surgery, treatment for infertility or indeed impotence, should be treated as health care needs by the NHS. Consider the example of breast cancer; while surgery to remove the diseased tissue is uncontroversial, it is more difficult to determine if breast reconstruction should be available on the NHS. This latter surgery will not contribute to the treatment of the disease, or restore function, but may contribute to the psychological well being of the woman and her subsequent rehabilitation. If health is defined in the broader sense, embracing the idea of well being, then breast reconstruction should be available on the NHS. It would also follow that a woman should have access to this type of surgery even if the

¹⁰ Dines and Cribb (1993: 3-19) discuss the difficulty of defining health. Further discussion will take place in chapter 5.1

¹¹ International Health Conference 1946 Official Record of World Health Organisation 2 no, 100 cited in Daniels (1985: 29)

reconstruction was not to remedy disease or surgery but solely to rectify personal preferences about size – assuming that the latter is causing psychological illness equivalent to that caused by disease.

While the legal rights of patients to health care on the NHS are established in the current British legislation, some authors¹² have argued for a moral right to health care. This is based on the idea that individuals have certain rights, which are intrinsic entitlements, regardless of what rights are established in the prevailing legal system.

Doyal (1995: 273) has proposed that ‘all humans should have equal rights of access to health care on the basis of equal needs.’ He seeks to justify this claim by suggesting that ‘physical and mental health are necessary conditions - they are ‘needed’ – for optimally successful social participation’ (Doyal 1995: 275). If people are unable to participate in normal social interactions, they will be unable to flourish and unable to fulfil their responsibilities to others in the community. However, Doyal does not clarify why we should accept that we have a duty to make people optimally successful at social participation. Many people choose to withdraw from social participation at particular times of their lives – following bereavement or the birth of a child.

Doyal (1995) suggests that people should not be denied health care, because physical and mental health are necessary conditions for becoming and remaining a good citizen and fulfilling whatever personal potential they may possess. He states that ‘People who are less healthy than they might be cannot help others to flourish’ (Doyal 1995: 275). This suggestion might lead to the unacceptable idea that people with disabilities or chronic illnesses are not good citizens.

¹² Doyal 1995, Daniels 1983, Daniels 1985

The notion of equal rights of access to health care on the basis of equal needs,¹³ as proposed by Doyal, raises a number of problems. How do you assess needs accurately? Does the mother with three dependent children need treatment more than the elderly man who lives alone? If we include the needs of the children for a parent, then we may meet 'more' needs by treating the mother. Can one really compare the needs of one patient with another? The stoic person who does not complain about the ongoing pain may be disadvantaged by any superficial assessment of needs.

Different people will have different priorities: the stiff knee for the ballet dancer may present an immediate medical need. However, a similar condition may not be a problem for the more sedate lecturer who chooses to avoid exercise of any sort. Doyal (1995: 276) admits that he is focusing on hospital care and has defined 'need' as 'the requirement for specific clinical intervention to avoid sustained and serious disability.' Accordingly, resources should be allocated to life threatening conditions and to those who are at risk of serious and irreversible disability, including those who are suffering acute pain. Doyal appears to focus on a restricted medical model of health care and he avoids the wider issues of whether we should promote the health and general well being of individuals. Elective surgery, cosmetic surgery, and treatment for impotence would not be a priority, within his approach.

Norman Daniels (1985) has also examined the idea of a moral right to health care. He argues that the right to health care is derived from the social obligation to guarantee 'fair equality of opportunity.' He suggests that health care is a special social good, which should be distributed differently from other kinds of social goods. The distinction is made because health care meets certain important categories of need: those that are necessary to preserve 'normal species functioning.' This is a more modest obligation than that suggested by Doyal, since Daniels (1996: 189) writes that

¹³ Medical need as a criterion for the distribution of health care will be discussed in chapter 3.1

‘we can characterise health care needs as things we need to maintain, restore or compensate for the loss of normal species functioning.’ Since serious impairments of normal functioning can adversely affect the capabilities of people, they may also impair the opportunity ranges for individuals as compared with the normal range for society.¹⁴

Daniels uses the term ‘health care’ broadly to include personal medical services and also preventative medicine and public health. He suggests that it embraces a diverse set of institutions and therefore the notion of a right to health care can imply a number of different things – both in regard to the extent of what is being claimed and with regard to the type of justification that it needs. Nevertheless, Daniels (1985: 35) concludes that ‘we should use impairment of the normal opportunity range as a fairly crude measure of the relative importance of health-care needs at the macro level.’

Daniels suggests that medical need arises from the loss of normal species functioning and it follows that health care should seek to treat both physical and psychological disease or injury, which adversely affects normal functioning. However, I would suggest that this approach might exclude certain health care provision such as cosmetic surgery, complementary therapies, breast reconstruction and health promotion. Even though they go beyond treatment for loss of normal functioning, these interventions are sometimes provided on the NHS, since they seek to promote the well-being of the individual. Indeed such health care is vitally important within a service, which seeks to promote the general welfare of individuals.

Daniels (1996: 194) admits that his account cannot resolve all distributive issues in health care and he suggests that other considerations may be relevant, in addition to maintaining a normal opportunity range. Anyway, Daniels is discussing the

¹⁴ Daniels recognises that other social conditions can affect opportunity, including lack of education and/or relevant job training

macroallocation of resources, while I am interested in the distribution of health care between individuals – the microallocation of resources.

In conclusion, while the legal right to health care in Britain is reflected in the statutory duties of the Secretary of State to provide a ‘comprehensive’ and ‘free’ health service to all, the extent of this right remains controversial. Even if we agree that there is a legal right to health care, questions remain about what is included within this right. The concept of health can be defined from a narrow medical perspective, focusing on diagnosis and treatment of disease or injury, or from a much broader and more inclusive approach embracing the well-being of the individual. The claim of a legal right to health care does not in itself clarify what duties and obligations are implied, or what services should be available on the NHS, or who should be eligible for care.

Despite the difficulties in determining the extent of a moral right to health care, for the purposes of this thesis, I will accept that there is a *prima facie* right to health care. There cannot be an absolute right to health care because we cannot meet all claims to health care, and therefore we cannot say that we ought to meet all claims. The central question of this thesis is whether individuals can forfeit their right to health care by their irresponsible behaviour. If nobody has a right to health care this question becomes meaningless. In the unfortunate situation where it is impossible to treat everyone, I wish to explore whether it is justifiable to withdraw or delay medical treatment from those people who have adopted an unhealthy lifestyle, taken risks or failed to comply with prescribed treatment.

1.6 Do individuals have a responsibility to maintain a healthy lifestyle?

While the rights of patients have been asserted in *'The Patients Charter'* (Department of Health 1991) and have been the focus of debate, there has been little discussion about any corresponding responsibilities of patients. The existence of rights is often balanced by certain responsibilities, which may impose obligations¹⁵ on the individual. Indeed the current Home Secretary, Jack Straw,¹⁶ states that: 'The Government's objective is to promote a culture of rights and responsibilities throughout our society. This Act' (The Human Rights Act) 'will make people more aware of the rights they already have but also balances these rights with responsibilities to others.' I wish to examine whether the right to health care imposes a responsibility on individuals to maintain a healthy lifestyle, either by avoiding known risks or by taking positive steps to promote their own health.

In Britain, contribution to the NHS is by compulsory taxation and there is a pool of resources, both financial resources and material resources such as donated organs and beds. If some people take risks with their health and use more than their fair share of resources, for self-inflicted illness, then others may be denied treatment. On the other hand, when people maintain a healthy lifestyle, and lower the incidence of disease and injury, then those who become ill through no fault of their own, may be able to benefit despite limited resources. The responsibility to maintain a healthy lifestyle may be owed to society as a whole because society will have to support those who become ill. Veatch (1981: 276-281) argues that where the need for health care is self-generated, through behaviour, which puts health at risk, it is not fair to ask society to bear the extra costs. In the NHS prudent individuals, who take minimal risks with their health, will subsidise those individuals who continue to pursue an unhealthy lifestyle or

¹⁵ I will use the words obligation and duty interchangeably

¹⁶ Cited in Home Office Press Office *News Release Government to "Bring Rights Home" on 2 October 2000 (12/07/00)*

partake in dangerous sports and are subsequently ill or injured. Gutmann (1995: 113) states that 'The medical needs that result from reckless behaviour may be so expensive to satisfy that society cannot then afford to meet the needs of other people who act responsibly but still suffer from misfortune.' In this way people who adopt unhealthy or risky lifestyles may cause indirect harm to others.

It is also possible for individuals to cause direct harm to others if they do not look after their health. When individuals suffer from an infectious disease and fail to take appropriate precautions there may be risks for others. Similarly, smokers can cause direct harm to others if there is no way to avoid the effects of passive smoking. We have a moral responsibility not to harm others, both in health care and in life generally, and it follows that individuals must take some responsibility for their health and lifestyle, since self-neglect can adversely affect others. Restrictions on certain types of behaviour are evident in our current legislation and are justified if there is clear evidence that harm to others is likely to result. For example, speed restrictions for motorists will reduce the severity of injury in car accidents and for pedestrians.

Individuals may also have a responsibility to maintain a healthy lifestyle because of ongoing commitments to particular people. For example, parents may have a special responsibility to adopt a healthy lifestyle because of their young children.¹⁷ When individuals become ill, or die prematurely, there is a tremendous loss for those who are dependent upon them. When Alison Hargreaves (Beaumont and Douglas 1995: 10) attempted to climb K2, following her successful climb on Mount Everest, there were criticisms and questions in the press following her death. Was she irresponsible to take such an obvious risk with her health and life, when she had two young children? If

¹⁷ Sons and daughters are also expected to be responsible for the care of their aged parents - particularly in a climate of reducing NHS and social welfare expenditure. It is not clear that the children of elderly relatives enter into a voluntary agreement to accept this duty, rather the caring role appears to fall upon them. Hence, Dworkin (1981: 26-31) suggests that responsibility is not always voluntarily assumed.

such criticism is accepted, it implies that women have a particular responsibility to maintain a healthy lifestyle while their children are young and dependent. (At the time Alison died on K2, two other male British Climbers were swept to their death in an avalanche, in the same range of mountains. Both men had children and yet there were no questions asked as to whether these fathers should have gone mountaineering.)

There are however inherent difficulties in accepting the claim that we have a responsibility to maintain a healthy lifestyle. Firstly, there may be competing obligations, where individuals take risks with their health, in order to fulfil other responsibilities. For example, firemen or lifeguards may deliberately place themselves in potential danger in order to rescue those in need. Secondly, the claim that individuals have a responsibility to maintain a healthy lifestyle does not indicate the kind of the duty, whether it is only a negative duty not to expose oneself to risks, or whether it is also a positive duty to improve health? Does the individual have to refrain from indulging in certain high- risk activities, or is there also a requirement for individuals to take active steps in order to maintain their health, including taking regular exercise, eating a high fibre diet, and putting on sun protection cream?

Positive obligations or duties can be described as those in which the individual should not merely refrain from acting but should perform certain acts (Fishkin 1982: 8). For example, you might have a positive duty to get an inoculation before travelling to a foreign destination, to minimise the risks of potential infection. It is tempting to suggest that there is a duty to avoid high risk activities,¹⁸ which are known to harm health, such as smoking, parachute jumping and excessive sunbathing, but to deny that there is a positive duty to take active steps to maintain health. However, the

¹⁸ Except when there are conflicting obligations. For example, many people take justified risks in their jobs: the window cleaner may be at risk of physical injury and the pub owner may work within smoke filled bar and others may just overwork and subject themselves to ongoing stress.

distinction between positive and negative obligations is not always obvious or clearly defined, particularly in regard to what is an omission. Does the responsibility to maintain a healthy lifestyle involve a positive obligation to take regular exercise and eat a high fibre diet? Or is this a negative obligation to avoid a sedate lifestyle and a low fibre diet?

The extent of such a responsibility is not clear, and there are limits to what can be expected of people. For example, the single mother who has little help with child care may find it difficult to partake in regular exercise. Should high-powered executives give up their stressful jobs and move out of the polluted cities in order to improve their health? Should people stop using the car and get on their bicycles in order to promote their health? The responsibility to maintain a healthy lifestyle raises the question as to how much sacrifice is necessary to fulfil the obligation.

Smiley (1992: 255) suggests that our judgements about the scope of responsibilities will be related to a variety of cultural assumptions about when, and how much, individuals can be expected to control their own behaviour. In particular, she focuses on our perception of social roles and communal boundaries. Responsibility for disease and injury can be assessed against a backdrop of expectations about who can and should act (or refrain from acting). For example, with the current knowledge of pregnancy and child development we might expect pregnant women to stop smoking. Prior to the extensive evidence of the potential dangers to the developing baby, we did not expect woman to give up smoking during pregnancy, but our expectations of social roles and responsibilities have changed with time and increased knowledge.

With increasing scientific evidence as to the factors, which contribute to disease generally, and in particular heart and vascular disease, we might expect individuals to modify their behaviour accordingly. The illness, which may result, is a harm that

affects not only the individual, but also their close community and members of their family and friends. Can people expect support from others and from limited health care resources, if they do not demonstrate responsibility to maintain a healthy lifestyle, avoid known risks and co-operate with advice and treatment from health care professionals?

Recent government documents emphasize the importance of individual responsibility: ‘individuals ... have a responsibility for their own health. Everybody should try to look after themselves better, by not smoking, taking more exercise, eating and drinking sensibly’ (Department of Health 1999: vii). There is also recognition that improving health is not solely an issue of personal responsibility, rather it is a balance between what individuals can and should do and wider factors such as air pollution, unemployment, low wages, crime and disorder, and poor housing. Nevertheless, the proposals to improve the health of the nation and achieve the set targets in key areas¹⁹ rely partly on what the individual can do. ‘Individuals are central to our new vision for better health. People need to take responsibility for their own health – and many more are doing so. There is a new and clear realisation that individuals can improve their health, by what they do and the actions they take’ (Department of Health 1999: 8).

There is no suggestion here that individuals who do not take responsibility for their lifestyle should forfeit the right to health care. However Emson (1992: 10) suggests that ‘we have arrived at the point when each statement on rights in relation to health care must be accompanied by considerations of duties and responsibilities.’ It follows that we might wish to explore whether priority should be given to those individuals who have maintained a healthy lifestyle, when choices have to be made between patients for scarce resources. There are two distinct reasons for prioritizing the prudent individual: Firstly, it may seem only fair to prefer those who are not at all to

¹⁹ Key areas include cancer, coronary heart disease and stroke, accidents and mental health ‘

blame for their illness or injury and secondly, it may encourage people to be responsible and hence save resources for those whose illness/ injury are undeserved.²⁰ Hence, individuals who continue to abuse their health and ignore advice about how to prevent disease and injury may have a weaker claim to limited resources.

However, before accepting that the responsible individual should be given preference in access to scarce medical resources, we should consider some preliminary questions. Which criteria could be used in practice to determine who should be treated, when it is not possible to treat everyone? Which criteria should be used? I wish to consider whether it would be justifiable and fair to use medical need, clinical and cost effectiveness, age, as well as desert, both for those who are chosen, and for those who are denied the first choice of treatment. This discussion will take place in chapter two.

In chapter three, I will examine some of the various theoretical accounts of distributive justice in order to determine if any of these enable us to establish a fair way to allocate scarce health care resources between patients. In chapter four, I will turn to other key questions for this dissertation: Do people make voluntary choices about their lifestyle, and does it make sense to hold them responsible for their health-related behaviour? In chapter five, I will examine what actions the government and health care professionals should take when trying to persuade people to adopt a healthy lifestyle? I will then examine some pragmatic problems inherent in any policy, which allocates health care resources according to the lifestyle of the individual. Finally, I will review some case studies where rationing according to previous lifestyle has occurred.

²⁰ However, people who do not change their behaviour because of the fear of becoming ill or injured may be unlikely to change their behaviour because of the threat of withdrawal of medical care. They may be unconcerned about their future generally and live for the immediate thrill.

Chapter Two

RATIONING SCARCE RESOURCES IN HEALTH CARE – AN EXAMINATION OF THE POSSIBLE CRITERIA

2.1 Criteria for rationing in health care

2.2 Medical need

2.3 Patient Desire

2.4 Clinical and Cost Effectiveness

2.5 Age

2.6 Waiting lists and lotteries

2.7 Desert

2.8 Conclusions

2.1 Criteria for rationing health care

In this chapter, I will examine a number of criteria, which could be used to allocate scarce resources in health care, including medical need, patient desire, clinical and cost effectiveness, age, waiting lists, a lottery system and desert. I hope to demonstrate that a pluralist approach should be used in decisions about which patient is treated. I will argue that some criteria including medical need, clinical and cost effectiveness, and patient desire are directly relevant to these decisions. In addition, lifestyle and age may be indirectly relevant if they affect the probable clinical outcomes of treatment.

I have argued that rationing is inevitable within the NHS, where rationing is defined as the withholding, or delaying, of beneficial treatment primarily because of limited resources. In health care, the issue is not whether to ration, but how to ration fairly.¹ It is therefore desirable to examine the various criteria on which rationing decisions have been made, and could be made, in order to determine if they would be fair both to patients who are given the treatment of first choice, and to those who are not. It might so happen that there is a just and workable way to distribute limited resources, that does not take into account previous lifestyle and behaviour. However, there may be no simple criterion on which to allocate limited resources and it may therefore, be justifiable to adopt an eclectic approach, using a number of variables, including even lifestyle, in order to choose which patient should be given limited resources.

This discussion presupposes that every effort has been made to raise extra resources, either by increasing the overall allocation to health care provision, or by improving the efficiency of the service. While the NHS White Paper (1997: 13) suggests that patients in the NHS will be treated 'according to need and need alone', it appears that a variety of criteria are, and have in the past, been adopted in practice.

¹ Hunter D.J. Rationing Health Care: the Political Perspective In *British Medical Bulletin* 1995, 51 (4) 877

2.2 Medical Need

The White Paper, '*The New NHS. Modern. Dependable*' (1997: 13) states that patients in the NHS will be treated 'according to need and need alone.' Many doctors, according to Gillon (1985: 95) prefer 'medical need' as the criterion on which to decide who should be treated when resources are limited. Since it makes no sense to treat people unless they have a medical need, it is surely a relevant and appropriate criterion on which to allocate health care. However, I suggest that 'need alone' is not sufficient to determine which patient should be treated, when not everyone can be treated.

Firstly, I have proposed that it is not always possible to treat everyone according to their needs because of limited resources (Chapter 1. 4). Secondly, it may not be reasonable to treat everyone according to their needs. The capacity of modern medicine to preserve life is so great today that intensive care beds and technological treatments could use vast amounts of both financial and staffing resources, to the detriment of other welfare needs of society. Excessive spending on health may reduce the available resources for education, housing and safe transport, all of which may impinge on the health and well being of individuals.

Thirdly, in the area of health care, where there are ongoing innovations and new drugs become available, it is difficult to determine the scope of medical need. Mason and McCall Smith (1994: 257) describe need as an 'imprecise' and 'elastic' concept. It is not, though the concept that is imprecise – but rather what things fall under it. According to Daniels (1981: 158) health care needs encompass 'those things we need in order to maintain, restore or provide functioning equivalents (where possible) to normal species functioning.' Consider the difficulty of applying this definition to determine what counts and what does not. For example, do treatments for infertility,

complementary therapies, lifestyle drugs, and certain psychiatric drugs satisfy medical needs or are these treatments merely a response to patients' desires? If these broader needs are included as medical needs, it will be impossible to meet them within the existing budget for health. Further criteria will be needed to determine which treatments should be offered.

Finally, if the NHS is committed to allocating treatment according to need and need alone, how should decisions be made between patients who have similar needs? Can one assess patients according to the seriousness of their needs, or the immediate threat to life? This would favour the allocation of resources to those patients who need life saving treatment, with an associated loss for other areas of care. Even if need is acute, should medical treatment always attempt to meet critical life threatening needs in order to prolong life, or does this depend upon other factors such as the predicted outcomes, clinical and cost effectiveness and potential quality of life for the patient?

I suggest that need cannot serve as the *only* criterion in distributing limited medical resources between individuals. If it is accepted that other criteria will inevitably come into play, is it reasonable to include amongst these others not only clinical and cost effectiveness but also considerations such as age or lifestyle, in order to determine which patient should be treated?

The distribution of limited health care resources between individuals who have similar medical needs is complex. We do not all have equal needs for medical treatment and it would not make sense to argue for equal shares. Swift (1995) makes the point that if other people get more health care than me, it does not in itself affect the characteristics of the value to me of the health care that I get. I can get all the health care that I need as a citizen even if others are getting more than me. Only in the case of health education might we wish to argue that everyone should have equality at the basic level;

for example, everyone should be informed of the merits of a healthy diet and the risks of smoking.

The assessment of 'medical need' will inevitably fall to the medical profession, who by merit of their education and expertise should be best qualified to determine medical need and clinical outcomes. For certain patients it may be decided that surgery is 'not clinically indicated.'² Hope, Sprigings and Crisp (1993: 379) suggest that this expression may indicate that it is not in the patient's best interests to undergo surgery. The probable outcomes are not favourable and might lead to poor quality of life or even death, which outweighs the possible benefits of the operation for the particular patient. Nevertheless, it is never possible to look into the future with absolute certainty and in current practice it is important to involve the patient as fully as possible in any decisions about the treatment and possible options. Individuals will have different values in assessing whether surgery is right for them and whether the inherent risks are worth the anticipated benefits. Decisions should not be based on clinical need alone and should involve input from the patient about what is right for him or her.

This is well illustrated by a case in practice where a young married woman with two young children was offered a kidney transplant. Medical staff decided she was a priority, but to their surprise she declined the transplant because she did not wish to undergo major surgery with its associated risks when she was managing well on home dialysis. She explained that she would rather have a transplant in the distant future when her children were older and the knowledge about transplantation had improved. Whenever possible, judgements about the quality of life or expected quality of life

² Hope, Sprigings and Crisp (1993: 379) suggest that the phrase 'Not clinically indicated' may sometimes be used when the doctor actually means there are no available resources for the patient. Indeed Ward (1986: 63) claims that the doctor may 'hide the truth' and should 'stop covering up for an inadequate health service.' There may be a genuine difficulty when doctors have to tell patients that there are no available funds and they may try to avoid this. While we may not condone this behaviour, nor underestimate the importance of honesty with patients (Jackson 1991, Higgs 1985), it is an understandable approach particularly in a climate where discussion of rationing is not often explicit.

should be left to the one person who knows best about the patient's plans and feelings - namely the patient.

In essence, medical need is one of the relevant criteria in the distribution of health care. However, it is not the only morally relevant criteria because it is impossible to meet all health care needs, and anyway it is unreasonable to attempt to meet them all. Other criteria should also be considered including clinical and cost effectiveness and patient preference. If health care is distributed according to 'need and need alone', as suggested in recent policy documents, several questions remain outstanding. For example: what precise needs should the NHS meet? Do drugs such as viagra, and other 'lifestyle drugs'³ meet medical needs, or patients' desires? Is long term care for the frail and immobile elderly a medical need or is it a social need?

³ For further discussion about 'lifestyle drugs' see Chapter 7. 5.

2.3 Patient desire.

In the majority of cases the doctor and the patient will negotiate common aims of treatment attempting to meet both medical needs and patient desires. While there is an increasing emphasis on patient autonomy within health care,⁴ and patients should be given a clear explanation of any proposed treatment before they consent to care, respect for autonomy does not imply that patients can demand a particular treatment or investigation. Rather respect for autonomy in the medical context implies that a competent patient's refusal of treatment should not be overridden.

Patients, doctors and the public may have different perspectives of what constitutes a legitimate claim on the health service. While the patient may feel that the treatment for infertility or varicose veins is of paramount importance, local managers in the NHS may not include the provision of such treatment in their services, because they do not classify these conditions as medical needs or priorities.

It is sometimes difficult to distinguish between patient desires and patient needs.⁵ If a patient desires certain physical treatment; for example, cosmetic surgery or treatment for infertility, the consequences of delaying or refusing treatment may have significant psychological effects for the patient. Psychological stress may lead to mental illness, which can in turn present as a clinical need. This is well illustrated in a case study presented by Ham and McIver (2000: 30) of a patient who was initially denied gender reorientation. The psychiatrist treating the patient and supporting the claim for surgery wrote that 'without the operation I fear she is at great risk of suicide, unable to live in the 'halfway' situation.'

⁴ Beauchamp and Childress (1989), Gillon (1985), Edwards (1996)

⁵ Wiggins (1985) discusses the distinction between needs and desires. Plant (1991:184-220) discusses how we might distinguish between needs and wants and examines the nature and claim of needs generally. Wilson (1986) also examines the distinction between patients' wants and patients' interests.

Nevertheless, doctors can be justified in refusing to provide what a patient requests and I have previously indicated that any legal, or moral right to health care on the NHS, is not absolute.⁶ If a patient requests an expensive but beneficial treatment or drug, the doctor can refuse to provide such care on the basis of cost or scarce resources. Doctors work with limited resources and there may be competing obligations to treat other patients.

However, Hellman (1997) suggests that there may be potential problems, such as the loss of trust, if the doctor considers the issue of societal cost, while making decisions about the care of individual patients. He goes on to suggest that there are two roles for the physician. As an agent of society, the physician must consider the greater good and be involved in the development of guidelines, directives and limitations on practice. As physician to the individual patient, the doctor should act in the best interests of each patient, within the limits of available resources.

In essence, patient desires should be considered in decisions about treatment.

However, patients are not entitled to demand particular treatments or care, at specified times on the NHS. Patient desires are one of a number of criteria, which should be included in decisions on resource allocation, alongside medical need, clinical and cost effectiveness.

⁶ Child b was not treated on the NHS despite her father's wishes, and efforts in the courts, to force the doctors to continue treatment. The High Court recognised that doctors act properly in refusing treatment and in taking financial constraints into consideration, although in this case the doctors who refused to treat Child b insisted that they were moved only by clinical considerations.

2.4 Clinical and Cost Effectiveness

Recent government policy (NHS Executive 1999: 8) has emphasized the importance of clinical and cost effectiveness. While the principle of effectiveness suggests that resources should be allocated to those treatments, which are clinically effective, the notion of cost effectiveness suggests resources should be allocated to those treatments, which will maximize benefit for cost.

Clinical effectiveness, based on the available research, remains an important aim in the medical treatment of patients. It is surely one of the principles, which should be considered in the allocation of resources. Hunter (1997: 76) suggests that the drive for clinical effectiveness now permeates the NHS at the level of rhetorical aspiration. A number of research centres, (including the NHS Centre of Reviews and Dissemination and the UK Cochrane Centre) disseminate findings and guidelines for effective practice.

The recently established National Institute for Clinical Excellence (NICE) will produce and disseminate evidence based guidelines to inform and support those professionals who have to make decisions about the management of patients and the use of new and existing treatments. On the basis of their appraisal, the then health secretary recommended that doctors in the NHS should not widely prescribe the anti flu drug relenza, because the effectiveness of the drug was uncertain. Relenza has not been banned, but doctors should take the guidelines into account when exercising their professional judgement. While NICE is not explicitly responsible for rationing, it is clear that the effect of their recommendations could result in the withdrawal of certain forms of treatment, from the NHS, on the basis of clinical outcomes and / or cost.

It seems entirely appropriate to allocate resources only to those treatments which are

effective and one might question any suggestion to do otherwise. However, in practice there are some problems with the idea that medical care should be allocated strictly according to clinical effectiveness. Many procedures have uncertain and unproved outcomes in health care. Bottomly (1993: 29) suggests 'Treatments that were previously common have been shown to be either ineffective or overused – for example grommets or tonsillectomies.' As a result the frequency of these procedures has declined. However, in some individual cases, these procedures are effective and will result in improved health for the patient, since it is often difficult to apply general guidelines or rules to particular cases (Beresford 1991). Medical research does not produce unambiguous results and it appears that there are often patients who prove to be the exception to the rule. Patients are not a homogenous group and they will respond to treatments and drugs in a variety of ways.

If doctors and / or managers decide to allocate medical resources according to clinical effectiveness, those treatments, which are judged to give some small benefit only, could be restricted. One might suggest that this is not rationing at all, because if a medical intervention is of limited benefit, then no one is being denied what they need (New and Le Grand 1996). However, it is rare to be able to predict future outcomes of health care with absolute certainty, and there are often significant benefits for the patient, even if there is no complete cure. Hence, Weale (1995: 835) states that 'the pervasive uncertainty about various aspects of medical practice means that it is not always easy to make the elimination of ineffective procedures the first priority of prudent health care rationing.'

In addition, it is relevant to note that clinical effectiveness is not always a priority for patients or their relatives. The placebo effect of certain treatments is well recognized. The idea that something is being done allows patients and their families to maintain hope and there is perhaps a chance that treatment may result in unexpected positive

results, even if research suggests it is unlikely in the majority of cases. Attention, care and an attempt at treatment may in themselves promote a sense of well being for the patient, even if clinical trials suggest that the physical improvements may be minimal.

It is not clear that the reduction of inefficient procedures will ameliorate the need to ration health care in the NHS. Throughout the history of the NHS there has been an increasing demand for new services and more expensive treatments. New drugs, such as viagra, beta-interferon for the management of multiple sclerosis, and xenical for obesity, suggest that demand will continue to increase and that the need to make difficult decisions about who receives care will remain.

For example, donepezil is a new drug for the treatment of Alzheimer's disease, which was licensed for prescription in the UK from April 1997. Benbow, Jones and Jolley (1999: 26) suggest that the clinical effectiveness of this drug is variable: up to one third of patients show improvements, approximately one third of patients will maintain their function rather than decline, and roughly one third will decline as expected. Since the cost of this drug is estimated to be about £1,000 per year, per patient, and Alzheimer's disease is not uncommon, there has been reluctance by some health authorities to fund this treatment (Benbow et al 1999). It appears that rationing is occurring in some geographical regions. Yet some patients, according to the research, would benefit from this drug therapy.

Economists, such as Williams (1992), are concerned not only with clinical effectiveness but also with cost effectiveness. The aim is 'to measure costs and benefits and choose the combination of health care that maximizes benefits for available resources' (Donaldson 1993: 81). Greater financial awareness, due to the devolved responsibility for the budgets to the fund holding practices, and the increasing business and economic values of the trusts, have made doctors more aware of the wider effects of their

decisions. It is surely naive, and unethical, for professionals to make choices about treatments without considering the wider implications for resources generally and the availability of resources for other patients, and future patients. Williams (1992: 7) states 'anyone who says no account should be paid to costs is really saying no account should be paid to the sacrifices imposed on others'. He suggests that there can be no ethical grounds for ignoring the effects of your actions on other people and he concludes a caring, responsible and ethical doctor has to take costs into account.

While economists may be able to measure the costs of the service, and evaluate the costs of proposed changes in the service, it is still necessary to define and measure the benefits. Since there are real difficulties in defining health, (which will be discussed in chapter 5.1) and objectively measuring the outcomes of health care, particularly in terms of patient well being, it may be more difficult to evaluate the benefits of health care.

Harris (1996) discusses the precise meaning of 'benefit' within the context of health care delivery, and suggests that there may be rival conceptions of what is meant by benefit. Firstly, patients may want what is most beneficial for themselves in terms of achieving the longest and best possible quality of life. In contrast, the providers, or funders, of health care may want to be selective in choosing those patients who have a prognosis, which indicates that they will do well in terms of overall survival and recovery rates.

Harris (1996: 273) asks the question: Should the patient with a ninety per cent chance of recovery always be preferred to the patient with a forty per cent chance, if they are in competition for resources for health care? If this question is answered in the affirmative, it is clear that those patients, who are judged to be high risk and have a poor prognosis, will be disadvantaged. This would appear to systematically

disadvantage those people who have existing chronic illness, such as diabetes and hypertension, which seems to be unfortunate, and contrary to the stated aims of the NHS.

The 'quality adjusted life year' or QALY, as described by Alan Williams (1985), is a means of evaluating the benefits of health care, both in terms of predicted quality of life and length of survival. A cost-effective medical procedure is one where the cost per QALY is low. However, several ethical concerns have been raised,⁷ with regard to the use of QALYs in practice. For example, the application of a QALY approach could result in reduced resources for certain vulnerable members of society. Since old people generally have a shorter life expectancy than the young, they will have fewer years to gain from treatment, and will therefore be disadvantaged by any assessment of QALYs. Disabled people may also be disadvantaged by subjective judgments about their quality of life.

Michael Lockwood (1988: 45) suggests that the QALY approach may seem intuitively unjust because the principle "To each according to what will generate the most QALYs" is potentially in conflict with the principle "To each according to his need." Conditions that can be treated cheaply, with a high probability of success, will score favourably on a QALY assessment. Yet such treatment should not always be given priority, over more costly lifesaving treatment. The patient who requires intensive care treatment may have the greater medical need, and may require lifesaving treatment. Public opinion seems to support the rescue principle, which implies that we should try to save people if their illness or injury is life threatening. Accordingly, it is justifiable to give priority to the individual who has, for example, suffered a heart attack, and requires coronary care, even if the same financial resources could be used to treat a number of less urgent conditions, for a greater number of individuals.

⁷ See Harris 1987, Harris 1995, Rawls 1989, and Haydock 1992 as examples of articles which critique the notion of QALYs and raise various ethical concerns.

Of course, some lives may unfortunately be too expensive to rescue and while great importance is attached to saving human life, there is no absolute legal or moral obligation to rescue an individual. Emergency care can be extraordinarily expensive and when it is, the rescue principle may be overridden in the public interest, or because of competing obligations.

In essence, both clinical and cost effectiveness are considerations, which should be included when making decisions about the allocation of scarce medical resources. They are not, however, the only relevant considerations and I suggest that they should be considered with other criteria such as medical need and patient choice. QALYs will give an indication of what procedures are cost effective and as such should be included within these decisions.

In this thesis, I wish to examine whether the allocation of health care resources should be partly dependent upon previous or current lifestyle. It is evident that certain behaviour, including smoking, and continued excessive eating, leading to obesity, may affect the recovery rates from surgery, and may therefore affect the clinical and cost effectiveness of certain treatments. Thus, some patients may be chosen, or not chosen, partly because their lifestyle has affected the probable clinical outcomes of treatment. This is not discrimination on the basis of lifestyle itself, but rather on the predicted clinical effectiveness of treatment for that particular individual. This will be justifiable in some cases and should be distinguished from a decision to allocate medical resources simply, or even partly, as a punitive measure for former unhealthy or risky behaviour.

2.5 Age

Chronological age is sometimes used,⁸ as one of the criteria in decisions about which individual should be treated when resources are limited and not everyone can be treated. While age is not officially identified as an obstacle to treatment on the British NHS (Aaron and Schwatz 1984: 34) (Department of Health 1994), it is evident that doctors do sometimes select younger patients in preference to older patients. The restriction of particular treatments to those individuals who are, for example, under the age of sixty-five, may be convenient and easy to administer. It may, however, be difficult to justify as a policy.

A variety of arguments are presented to justify the idea that there should be limits to medical treatment for the elderly. Firstly, by treating the younger patient, more years of future life will normally be saved. (This is an important consideration in the assessment of QALYs.) However, it is worth noting that it would be more appropriate to base rationing decisions on 'biographical'⁹ age, general fitness and health status, rather than chronological age, since there is enormous variation in the life expectancy for individuals of the same chronological age. Callahan (1987: 164) suggests that age is 'the equivalent of such typical medical indicators as weight, blood pressure, or white cell count.' These variables are usually evaluated within the context of an overall physical assessment and in isolation they are a poor indicator of health.

Secondly, Daniels (1985) argues that limited medical resources should be restricted for the elderly in order to free resources for the young. He does not visualize the problem as one of distribution between competing groups of individuals – young and old – but

⁸ Examples of rationing medical resources according to age are presented in chapter 1. 3.

⁹ Rachels (1986: 50) makes a distinction between *being alive* (in the biological sense) and having a *life* (in the biographical sense). Thus a patient can be alive, and unconscious in a coma, but valuable biographical *life* has ended, if the coma is irreversible. Biographical age gives an indication of stage of life reached and it may differ from chronological age.

he proposes that the issue should be understood in terms of allocating medical resources throughout the duration of the *same* life. If you have limited medical resources, you might choose to allocate a greater proportion within the early or middle aged years, with a correspondingly reduced amount in later life.

Daniels adopts a Rawlsian approach in order to determine a just distribution of resources between the various stages of life. What, he asks, would the prudent planner choose in a situation not dissimilar to Rawls' original position? ¹⁰ Prudent agents must attempt to determine which principles should govern the distribution of health care, knowing nothing of their own age, family situation, health status, genetic history, socioeconomic position, and such like. If resources are limited, Daniels suggests that prudent deliberators would give priority to enhancing the individuals' chance of reaching a normal life span, rather than extending the normal life span. In addition, they 'would seek a health-care and long-term care system that protected their normal opportunity range at each stage of their lives' (Daniels 1985: 103).

According to Daniels, a greater proportion of medical resources would therefore be allocated to those conditions, which occur in early life, rather than on preserving life after its normal span. Expensive life saving treatments might be restricted to younger patients, and denied to those after the age of seventy, seventy-five. (Daniels is not specific about the precise age.)

While Daniels suggests that medical resources should be allocated to protect the normal opportunity range during each stage of life, it is not obvious that there will always be enough resources even to achieve this goal. For example, Daniels' approach does not clarify whether infertility treatment should be provided, and such treatment

¹⁰ Daniels himself suggests that there are important differences between his view and Rawls' veil of ignorance. The prudent agent should use straightforward maximising reasoning rather than adopting a strategy to maximise the position of the worst off. See Daniels 1988: 88-89.

could meet important needs necessary to maintain normal opportunities for those of childbearing ages. In reality, choices may still have to be made between competing patients and defensible criteria will be required in order to justify the decisions made.

In addition, Daniels does not elaborate what precise policies could be implemented in order to put age based rationing into practice in a just way. Battin (1987) suggests that while we may hope that age based rationing and denial of treatment, or indeed delay in treatment, may bring about an earlier peaceful death, this is not guaranteed. Rather patients might have a prolonged period of morbidity and chronic disability with associated pain and discomfort.

Thirdly, Callahan (1993) proposes that age could be used as a standard to restrict the allocation of expensive, high technology, life-extending treatment. He presents various principles to support the idea that this form of treatment should be withheld from the elderly: 'After a person has lived out a natural life span, medical care should no longer be orientated to resisting death.' (Callahan 1987: 25) Hence when a person has reached a certain age, say late seventies or early eighties, death should be accepted as the normal course of life. Individuals have usually accomplished most of their life goals and opportunities have been fulfilled, so that death is not premature or untimely. Callahan emphasizes that suffering should be relieved for the elderly, however old, but that life should not be extended. The existence of medical technologies, which can be used to extend the life of the elderly, does not imply a duty on health care professionals to use them.

Callahan suggests that over the next twenty to forty years all developed countries will be faced with an increasing financial burden to provide health care for the rising numbers of elderly in the population. While acknowledging the elderly do have a substantial claim upon public funds, it is not and cannot be an unlimited claim. 'Not

only is an unlimited claim likely to be utterly unaffordable, it would place an unjust burden on the young, whose taxes must pay for such a claim' (Callahan 1993: 24). The aim of such a policy is not to reduce current expenditure but rather to control the expected escalation of future costs in a 'fair' and 'balanced' way. Indeed Callahan emphasizes these changes should be implemented over a period of years so that attitudes and expectations about old age can change gradually.

While Callahan's arguments are clear and the economic figures may be convincing,¹¹ it is not obvious why this proposed policy, which gives priority to the young for life saving treatment, is fair to those of us who are inevitably approaching old age. Rather the policy seems to be discriminating against the older members of the population merely because they represent an increasing percentage of the total population and represent a group who will probably make heavy demands on the health service. Is it permissible to withdraw resources from the elderly, and continue to treat those individuals who persistently ignore health advice by continuing to take risks with their health, by pursuing activities such as smoking, sunbathing or having unprotected sex? If the current health statistics (Department of Health 1995) are to be believed, these individuals will also make considerable future demands on the health service.

Hunt (1993) challenges Callahan's arguments both on the grounds there is little evidence that the economic savings would materialize and on ethical grounds. He argues that a policy of withholding certain medical treatments from the elderly would 'curtail' the autonomy of the aged and would treat elderly people as the means to a greater social good rather than as ends in their own right.

Similarly, Baumrin (1991) proposes that the autonomy of the elderly should be respected and they should be allowed to fulfil their life plans and live as long and as

¹¹ Grimley Evans (1993: 45) suggests that the implications for costs arising from the aging of the British population are not as great as is often assumed.

well as they can. In addition, Baumrin suggests that the doctor's normal social role is to treat disease and trauma in order to improve our life prospects. If this role is perceived to change and doctors are seen to be 'the arbiters of who should live and who should die' (Baumrin 1991: 159), it could lead to widespread insecurity and loss of trust.

The most convincing argument for giving priority to the young in the allocation of scarce medical resources is the fair innings argument. Harris (1988) accepts that if we have limited resources and are only able to treat one person (say there is only one ventilator or donated liver) we may justifiably prefer to treat the younger person in preference to the older person who has had a good or fair innings. Lockwood (1988) also uses the 'fair innings' to justify treating the younger patient in preference to the older patient. The younger person should be given priority in order to maintain equity in terms of years of life lived (Lockwood 1988: 50). I agree with the fair innings argument because intuitively the death of a young person seems to be a greater tragedy than the death of an old person. There is a feeling of incompleteness and unfulfilled potential when a young person dies. In addition, it is difficult to argue persuasively against the fair innings argument.

However, the fair innings argument should only be applied when there is a significant age difference between the individuals. In the unfortunate and rare situation where only one patient can be treated, the sixteen-year-old should be given priority over a seventy-year-old, with similar medical needs and probable clinical outcomes. In a situation of forced choice, but only then, it would be unfair to rescue the older person who has had a good innings and let the young person die when he / she has not had a fair innings.¹²

¹² I propose that the fair innings argument is only one of a number of relevant considerations in decisions about which patient should be treated, when not all can be treated. There will be other factors, which should also be considered in these decisions, such as the expected survival of each patient and the probable outcomes of treatment.

In conclusion, age does not always reflect biological fitness, quality of life or indeed a particular set of values, and it should not be used merely because it provides an easy way to make decisions about how to allocate limited medical resources. It is clear that certain elderly individuals, within their seventies, who are fit and have maintained a healthy lifestyle, will benefit from high technological life saving treatments and may extend their lives for many valuable years. People of all ages have a right to be treated as individuals and not as members of a uniform class.

Nevertheless, age is sometimes directly relevant in decisions about who should be treated. When there is a significant age difference between the young and older patient, I have proposed that it is fair to give priority to the younger person on the basis of the fair innings argument, if choices have to be made between patients. Age may also be indirectly relevant as for example if an elderly person has a number of degenerative conditions, and is generally unfit. In this latter scenario, this is not rationing based on older age 'per se,' but rather on the predicted outcomes of treatment for those individuals who are not healthy.

2.6 Waiting lists and lotteries

Shortly after the NHS was established it became evident that the demand for services was greater than the capacity to treat patients. General practitioners became the 'gatekeepers' to specialist services, making decisions about which patients would be referred to specialist services. When patients were referred to hospital consultants, they often had to wait weeks or months for their initial appointments and subsequent treatments. Queuing for treatment is still evident in the NHS today and there is considerable debate about how to manage waiting lists.¹³

In essence, if resources are limited, waiting lists may be seen as at least as fair as many of the alternatives. However, questions about who is eligible to join the waiting list, and whether certain patients should be given priority on the basis of need should still be examined. Access to the waiting list is dependent on medical judgement and may vary according to professional evaluation. Factors such as lifestyle and age may be used as criteria upon which to deny or delay people access to the waiting list. Harry Ephlick was denied access to investigations and the waiting list because he was a smoker, and he subsequently died before receiving treatment.

The present system appears to give priority to those who have waited the longest, based upon the notion of 'first come - first served'. However, in practice, this will penalize the stoic and may disadvantage those who seek help at a later point in the course of their illness. I would suggest that those individuals who have severe pain or are unable to fulfil their normal activities should be given priority over others with less severe and less immediate needs. If considerations of need are not taken into account,

¹³ Department of Health *Getting Patients treated: the waiting list action team handbook*.
Department of Health 1999

then waiting lists may become unjust. It is of course accepted practice to ignore waiting lists in extreme cases, where a patient is acutely ill or collapses. For example, the patient who has a myocardial infarct will be admitted according to need irrespective of any waiting list. Other patients who are in severe pain and have a life threatening illness may also merit priority over others with less urgent clinical needs. Doctors can organize waiting lists to reflect the differing needs of individuals, but this introduces another criterion in decisions about which patient should be treated first.

Some patients with particular conditions are currently given priority within the system and may be guaranteed a specialist appointment within a set time period. For example, the NHS Executive (1998) has set a target of two weeks for a specialist to see a woman with suspected breast cancer. Currently, this is not guaranteed for patients with other forms of suspected cancer. This 'targetting' of particular groups of patients may be justified if there are identified needs and early treatment will lead to beneficial outcomes. However there is a risk that it may be a response to media campaigns and politically motivated.

While the use of waiting lists is evident in practice, the allocation of medical resources according to a lottery is a theoretical proposition, (Broome 1988: 60, Harris 1988: 121) that is not reflected in current practice. A lottery system distributes resources randomly and gives every individual an equal chance of being treated. Harris (1988) has suggested that a lottery will reflect the belief that the life and health of each person matters and that each person is entitled to equal concern and respect. However, drawing lots ignores the varying needs of each individual and could result in problems in practice. Williams (1992: 9) questions 'who is eligible to enter this lottery, what the prizes are, how soon and how often you can re-enter the lottery if you fail to win the first time, whether 'tickets' (especially winning tickets) can be traded or given away, and so on.' Since individuals rarely have equal medical needs, and there is a

vast difference between life saving and life-enhancing procedures, the lottery system has some limitations in reality.

2.7 Desert

Consider the scenario where a drunk driver steers his car off the road and hits a pedestrian, who is walking on the pavement. The driver and the pedestrian are both critically injured and taken to the nearest hospital, where it is judged that they both require intensive care treatment. There is only one bed available.

LeGrand (1991) describes such a situation and asks who should receive priority for treatment? He suggests that 'most people would find it more acceptable to allocate the bed to the pedestrian, on the grounds that the driver was, to a large extent, at fault for his predicament' (LeGrand 1991:103). This seems to suggest that the pedestrian deserves the intensive care bed more than the drunk driver who has contributed to his own (and the other's) medical needs by his reckless behaviour. He has made a choice to drive having consumed excess alcohol and he should accept the consequences of his behaviour.

Glover (1977) presents a similar case where there is only one intensive care bed and two people in need are brought into hospital. One is a bank robber and the other is a man who heroically went to the aid of a policeman under fire from the robber. He suggests that in such a case we would favour treatment for the hero on the difference of desert. However, Glover emphasizes that in this case the risk to life is directly related to the acts being judged and this is not the same as allowing general character evaluations of moral worth to dictate who should be given priority in the allocation of medical resources.

Nevertheless, these examples highlight that in extreme situations, desert may be considered to be a relevant factor in the allocation of resources. In practice, decisions about who receives the one intensive care bed are rare and other criteria might be

considered relevant. People are unlikely to have similar medical needs, and one patient may be at greater physical risk than the other and so merit the intensive care bed on the basis of acute need. Alternatively, if we say that the driver of the car was nineteen, while the pedestrian was ninety-two, we may feel uncomfortable about our former decision to treat the pedestrian in Intensive Care. Decisions are multifaceted and it is obviously unrealistic to isolate one criterion, such as desert, and exclude other relevant factors.

If desert is sometimes a relevant criterion in acute situations, should it have a role in determining the allocation of resources in other situations? Is it justifiable to give priority to the healthy eater, who exercises regularly and avoids known risks such as smoking and excessive sunbathing? Should the cautious and sensible individual be given priority over the risk taker who takes part in hang gliding and dangerous sports? In other areas of our lives rewards and goods are distributed according to desert - the well qualified person is offered the job and the most successful sportsman is paid handsomely in prize money. Society generally accepts the notion of desert as a fair criterion on which to allocate certain resources, although there are frequently arguments as to the size of the allocated awards. It might follow that it would be fair to allocate medical resources partly on the basis of desert. For example, those people who had previously donated blood might be considered first for major surgery when the need for transfusion was anticipated. Likewise, those who had previously registered as a potential organ donor might be given priority if they themselves required a transplant.

Jarvis (1995: 202) suggests that 'legislation governing organ donation be amended such that all and only those who identify themselves as potential donors are eligible themselves to receive transplant organs.' He claims that such a scheme would satisfy the requirements of justice, because differences in access to transplantation

programmes would be based upon relevant differences; only those who elected to act as possible donors after their death would benefit from the transplant scheme. In the light of the current shortage of donated organs, this proposal appears to have various advantages; not least that it might increase the available number of organs, thereby promoting the good for the population as a whole.

There are however, inherent problems in this proposal presented by Jarvis. One would need to be certain that the decision 'not to donate organs' was deliberate, well informed and taken with an understanding of the consequences. Some people may never have thought about donation, while others may have been encouraged to explore the issues and complete a donor card by an enthusiastic specialist. In other words, the decision "not to donate" should have been autonomous, and not the result of apathy, misunderstanding, or plain ignorance. If the 'modest proposal' as described by Jarvis were accepted, it would introduce the notion that past choices and behaviour were acceptable criteria on which to allocate health care resources.

It follows that those people who deliberately and knowingly choose an unhealthy lifestyle could be held responsible for their former behaviour and forfeit subsequent health care on the basis of desert. However, we need to examine some key questions before accepting this suggestion. Do people really make voluntary choices about their lifestyle? Should doctors or any one else, make judgements about the behaviour of others when determining who should be given priority in the allocation of scarce health care resources?

2.8 Conclusions

In this chapter, I have examined some of the criteria, which could be used to select patients when not all patients can be treated. I have argued that a pluralist approach should be adopted, where medical need, patient desire, clinical and cost effectiveness are always considered in decisions about the allocation of scarce medical resources. Other criteria such as age¹⁴ and lifestyle choices should also be considered, at least in so far as they affect the probable outcomes of treatment. It follows that doctors should be involved in decisions about who should be treated because they have the relevant knowledge about medical needs and probable treatment outcomes.

Generalizations about people, such as the elderly or risk takers should be avoided. Just as ninety-year-olds vary in their physical and mental health so do people who adopt unhealthy lifestyles. We should not assume that smokers will always have poor clinical outcomes following surgery. Some smokers may exercise regularly, eat a healthy diet, have a stress free lifestyle and only smoke a limited number of cigarettes. In addition, they may be lucky and have genes, which predispose them to a long and healthy life, so that the probable outcomes of surgery may be favourable.

This pluralist approach to the allocation of health care resources means that doctors will have to make difficult decisions about individual cases. To repeat, they will have to consider medical need, clinical and cost effectiveness and other criteria such as age and lifestyle choices, where relevant to probable outcomes. However, other characteristics such as social worth, number of dependents, geographical postcode are more controversial and contrary to the principles of the NHS. I will not discuss these here.

¹⁴ Where choices have to be made between patients of significantly different ages, the fair innings argument may be relevant. However, in practice, these choices are rare and there are normally other relevant differences in medical needs and probable clinical outcomes for each patient.

In this thesis, I wish to examine whether former and current lifestyle choices are directly relevant criteria to include in decisions about who should be offered treatment, when not everyone can be given the treatment of first choice. I have suggested that lifestyle can affect the outcomes of certain treatment and surgery, and it follows that lifestyle can impact on the clinical and cost effectiveness of some medical care, and when it does so, it is a justifiable criterion to include in decisions about rationing. This is not to suggest, though, that it is just to allocate medical resources according to former lifestyle 'per se', which is the central issue under examination in this thesis.¹⁵

¹⁵ While I have noted that in extreme situations, such as the drunk driver who injures both himself and a pedestrian, desert may be considered to be a relevant factor in the allocation of scarce resources (Section 2.7), in practice these cases are rare. In most cases, there will be other relevant differences of medical need and probable clinical outcomes. Hence the decision about which patient should be allocated scarce resources is likely to be made on these criteria. Even if, in this scenario, we think desert is relevant, it may still be a serious mistake to infer that as a general policy doctors should include desert per se among the criteria they apply to select patients for scarce resources. As the saying goes: hard cases make bad law!

Chapter Three

DISTRIBUTIVE JUSTICE AND THE ALLOCATION OF HEALTH CARE RESOURCES

3.1 Theories of distributive justice

3.2 The Libertarian approach to justice

3.3 The socialist approach to justice

3.4 Justice according to Rawls

3.5 The Communitarian approach to justice

3.6 Conclusions about distributive justice and the allocation of health care resources

3.1 Theories of distributive justice

When there are limited resources and we can only treat some patients, what principles should guide us in choosing which patients should be given priority? This is a difficult question and a variety of different theories of distributive justice, emphasising different principles, have been appealed to over the years. The various conceptions of justice have implications regarding both what people deserve and what they are entitled to possess.¹ The various theories of justice will disagree in precisely what criteria should be used to differentiate individuals. For example: in essence the Aristotelian approach would allocate benefits according to merit (Aristotle 1955: 178), while the socialist principle, as described by Nell and O'Neill (1992) would allocate benefits according to need.

Bernard Williams (1973) argues that if you differentiate between individuals and treat them in different ways there must be relevant reasons. In the allocation of health care resources, it would obviously be unfair to discriminate on the basis of race, colour, or intelligence. In chapter two, I have suggested that relevant criteria include medical need, clinical and cost effectiveness and patient desire and I wish to determine whether the patient's lifestyle could be a relevant criterion to include in decisions. Williams also makes the relevant point that the reason for treating people in different ways must be 'socially operative.' In reality, any policy, which allocated resources according to lifestyle, must be workable, and it must be possible to implement it in a fair way.²

In this chapter, I will attempt to clarify some of the prominent contemporary approaches to justice and discuss their implications for the distribution of health care

¹ I make this distinction because someone might be owed money according to a contract, but he or she might not deserve it.

² I will explore the practicalities of implementing a policy to allocate health care resources according to lifestyle in chapter 6

resources. I have chosen to discuss libertarianism; socialism; the social contract as proposed by Rawls; and the communitarian approach to justice. In each case the theory appeals to a different ultimate value.

I am not including discussion of the feminist perspective of justice even though it introduces some valuable ideas. Feminists are interested in particular questions: ‘What constitutes the oppression of women and how can that oppression be ended?’ (Kymlicka 1990: 238). Discussion focuses on topics such as the private sphere of life in the home, relationships between men and women, moral development, and the education of children. It would be misleading to suggest that these issues are not relevant to health care provision generally. The roles and expectations of doctors and nurses have historically been linked to the male / female role and health care provision for women in a male dominated framework should be explored. However, the feminist theory is not obviously helpful or relevant to the central question of this thesis, which concerns the allocation of scarce resources, according to lifestyle. In addition, contemporary feminist political theory is extremely diverse in both premises and conclusions (Hospers 1992) embracing radical feminism, libertarian, socialist, liberal and communitarian feminism.

Each of the philosophical theories of justice, which I am going to discuss, gives us some insight into the distribution of health care resources. However, each theory seems to be subject to inherent problems and there is no easy or obvious solution to the question of distributive justice. The current literature presents a variety of views concerning the notion of justice reflecting the present pluralist society and range of political beliefs. To rely on one approach would inevitably mean by-passing relevant material and ideas. I have therefore chosen to survey contrasting theories of distributive justice and will explore each theory in relation to the allocation of limited health care resources. In each case, I will also examine whether lifestyle would be a

relevant criterion on which to ration scarce medical resources.

I make no attempt here to defend any one perspective of justice in preference to the alternatives. Neither do I aim to produce an in depth analysis of the concept of justice. Rather, I discuss the theories in relation to the central issue of this thesis - the allocation of limited health care resources between individuals. My aim is simply to establish whether the allocation based partly on previous life style is unjust according to any of these theories.

3.2 The libertarian approach to justice.

The libertarian conception of justice treats liberty as the ultimate political ideal, where liberty is generally defined as the absence of interference or constraints by other people. 'Every human being has the right to act in accordance with his own choices, unless those actions infringe on the equal liberty of other human beings to act in accordance with their choices' (Hospers 1992). Libertarians claim that there are a number of rights, such as the right to liberty, the right to life, and a right to property. However, while these rights do entail a duty - the duty is usually interpreted to be that of forbearance, which means that other people must refrain from violating your rights or choices. For example: your right to life means that other people must not kill you, (unless perhaps you have consented to such an action and therefore waived your right as in the case of voluntary euthanasia). This means that the right to life, as perceived by the libertarian, is not a right to receive health care and resources necessary to preserve one's life. There is no corresponding duty or obligation on others to provide such care.

Libertarians, such as Robert Nozick and the late Friedrich Hayek, advocate that the sole function of governments should be to protect the individual from encroachment or aggression by others. Nozick proposes a 'minimal state, limited to the narrow functions of protection against force, theft, fraud, enforcement of contracts, and so on' (Nozick 1974: ix), and he argues that the proper role of the state is that of the nightwatchman. If the state widens its powers to provide services, such as health care, then it will infringe the rights of individuals to live their lives as they choose, compatible with the equal right of all other human beings to live their lives as they choose (Hospers 1992).

Indeed, welfare rights are not generally recognized in the libertarian approach (Sterba

1992: 6). The right to free medical care would inevitably result in some people having to be coerced into providing such a service with the associated loss of their freedom, which would be contrary to the ideal of liberty. Accordingly, there is no role for the government to provide a health care service such as the NHS. Coercion in the form of a compulsory taxation for all citizens to finance the service would not be justified, even if there were some obvious benefits for certain individuals.

Libertarians could approve of a charitable health care system financed by voluntary donations, because this would not involve the coercion of individuals. People could give money, time and specialist services when they chose to contribute. We might still feel that the rich or skilled were morally blameworthy if they refused to help those individuals who were unable to meet their basic welfare needs, but this would not justify coercion, according to the libertarian view. In addition, libertarians would generally support an extension to the free market in health care so that people would buy and sell health care provision in the same way as they buy and sell other commodities such as computers, food and housing. This principle could also be extended to the sale and purchasing of human organs such as kidneys, blood, sperm or eggs, so that individuals could make choices about the use of their own bodies.

Nozick (1974: 234) argues that doctors should be able to distribute their services according to their own financial criteria and to meet their own goals. They should be free to set fees enhancing their salaries and ensuring their security as they choose. The providers of any service should be able to control the distribution of the service, choosing their clients and the terms of service, and doctors are no different.

In making this argument, Nozick dismisses the claim by Williams (1973: 240) that 'the proper ground of distribution of medical care is ill health.' Williams suggests that medical treatment meets a need and should be allocated on the basis of this need and

with reference to no other criteria. He argues that if treatment costs money then the irrelevant criterion of financial wealth becomes significant in who can obtain treatment. Distribution according to the economic market introduces disparity between the rich and the poor, because there is a situation where people with the same medical needs do not receive the same treatment. Williams, like Aristotle, claims that if men are treated in different ways there should be a relevant reason. He concludes that in the distribution of medical care, financial wealth of potential patients is not a relevant criterion for the just allocation of treatment.

Nozick (1974: 234) criticises the first premise of this argument and suggests medical need is not the only proper criterion for the distribution of health care resources. He claims that there is no support for this argument and he asks if barbering should be distributed according to barbering need, rather than the wishes of the barber himself. The barber may, for example, only wish to cut the hair of those who give very generous tips and he should be allowed to act accordingly. In other words, the internal goal of the activity should not necessarily take precedence over the person's particular reasons for carrying out the activity. From his libertarian perspective, Nozick emphasizes that doctors should be able to allocate their services as they wish and according to their own professional and personal values. This approach would clearly be incompatible with a state operated NHS where fees and salaries are established and controlled by the government.

Libertarians, such as Hayek and Nozick, are primarily concerned that the laws of a free society should enable individuals to act in the pursuit of their own purposes and their own good as they perceive it. Any attempt to secure a particular pattern of the distribution of goods and services to individuals within society (whether it is based on the public authorities' perception of needs, merit or desire) is opposed. Libertarians are not generally concerned with the outcomes or results of the framework because

they argue that the outcomes which result from individuals pursuing their own conception of the good will be just, provided there is respect for the freedom of others. In other words - the free market is inherently just. An injustice occurs if individuals are coerced and unable to make use of opportunities, as they would wish.

Libertarians reject the idea that we are under any obligation to rectify unequal circumstances, unless maybe we have created it by force of fraud. When this theory of distributive justice is applied to the provision of health care there are potential problems. Many people, who are not libertarians, will intuitively feel that it is not just to allow the naturally disadvantaged to experience ill health, pain or suffering, with no medical care, or for children to be denied health care because they are born into a poor family.

There is also something contradictory in this theory which suggests the ultimate value is a commitment to the principle of liberty and allowing people to make their own choices, (self determination), and yet acknowledges no obligation to rectify those circumstances which can undermine the ability of individuals to make choices. Ill health is obviously a factor, which naturally contributes to the loss of freedom; people are restricted and unable to take advantage of opportunities. One might argue that the rationale for society to provide a health care system is to promote health generally and at the same time thereby promote individual freedom. Health is one of those background conditions which is vital to enable individuals to achieve the freedom to live their lives as they choose. It should therefore be treated as a special case and not subject to the principles of the free market.

Graham (1988) has examined this libertarian argument and questioned some of the underlying assumptions. He concludes there is no single uniform concept of health and it is therefore unlikely that the rationale for the provision of health care is a single

formula. He states that 'there is still plenty of scope for intelligible disagreement about the importance of health in relation to other values' (Graham 1988: 115). It is not therefore justified to assume that all individuals will value health more than other goods. They should be free to decide for themselves if they wish to contribute to health insurance, and whether they adopt a healthy lifestyle, or take risks, which might contribute to future trauma or disease.

Graham (1988: 100) views health as a cluster of different conditions and suggests that the health service should treat some conditions, which are life threatening and result in pain and disability. However, health care also caters for many less romantic ailments such as acne, constipation or ingrown toenails, and a number of conditions, which result from self-chosen lifestyles, such as headaches which may be the result of a hangover rather than a life threatening aneurysm. If ill health is viewed as a cluster of different conditions, it follows that the rationale for providing health care will be dependent on a variety of arguments. It is more difficult to justify the treatment of these latter conditions on the NHS.

According to Graham, health is a partly subjective, evaluative concept and it is not just an anatomical or physiological concept: health is determined in part by what matters to the individual, relative to his or her own goals and life expectations. He goes on to suggest that health is one value for people but it must compete against other values such as the pleasure of smoking, eating chocolate, looking beautiful and taking part in exciting sports. The libertarian emphasizes that the individual must be allowed to choose between these values and reality shows that people will adopt hobbies and lifestyles, which pose a significant risk to health.

Graham, like many other libertarians, concludes that the provision of general health care must be left to people to choose for themselves. There is no objection to private

health insurance schemes because the individual can choose or decline to take part. There is however no justification for a compulsory system of health care provision for all citizens (such as the NHS) financed out of compulsory taxation. This involves coercion, which cannot be justified even if there are welfare benefits for some.

Sterba (1992) has presented an argument to justify the welfare state within a libertarian framework. He suggests there is a conflict of liberties between the rich and the poor: 'In this conflict situation, the rich, of course, have more than enough resources to satisfy their basic needs. By contrast, the poor lack the resources to meet their most basic nutritional needs even though they have tried all the means available to them that libertarians regard as legitimate for acquiring such resources' (Sterba 1992: 56). In a society where there is no welfare state the liberty of the poor is at stake since they are unable, within the existing laws governing property rights, to take from the surplus possessions of the rich in order to meet their basic nutritional needs.

Sterba suggests that we have a choice between accepting that the rich should have the liberty to use their surplus resources for luxury purposes, or that the poor should have the liberty to take from the rich what they require to meet their basic nutritional needs. For Libertarians the ultimate ideal is liberty and this choice represents a conflict of liberties, and we must apparently choose one liberty and reject the other. Sterba concludes that the liberty of the poor to take from the surplus resources of the rich is morally preferable, because it would be unreasonable to expect people to make a sacrifice, which could potentially result in their starvation.

While Sterba cites nutritional needs it would seem entirely appropriate to extend this to embrace basic health care needs which are necessary to support normal life. I doubt that the argument could be extended to cover all the services available on the current NHS such as cosmetic surgery, elective surgery for varicose veins, or infertility

treatment and it is relevant that some of these services have already been withdrawn, under recent local purchasing agreements. To take the extreme example, it would surely be unreasonable to expect the poor to sacrifice life saving medical treatment in order to allow the rich members of society to maintain the freedom to buy life enhancing luxuries. It would also seem unreasonable to expect people to suffer pain and severe physical or psychological discomfort in order to preserve the liberty of others to use their surplus resources to acquire luxuries.

Some libertarians would not agree with the arguments presented by Sterba. Machan (1992) claims there is no foundation for 'why the needs³ of some people must be claims upon the lives of others.' Machan also suggests that genuine cases of the helplessly poor are indeed rare, and often the result of political oppression, rather than natural disaster or disease. He points out that the poor should ask for help, and that it would then be immoral if the rich failed to offer help, if it involved minimal sacrifice for them. Charity allows people to give on a voluntary basis and is therefore acceptable within the libertarian approach to justice.

However, if people have contributed to their poverty or illness by their choices and behaviour, the rich may feel less inclined to offer support. Sterba's proposal seems to imply that the rich have a duty to help the poor, but this cannot be regardless of *why* they are poor. If someone has contributed to their need for health care, why should others have to help them?

The question of whether from a libertarian stand point, lifestyle would be a relevant criterion on which to allocate limited health care resources remains. Libertarians emphasize that people should have the freedom to choose their own good and to decide how best to promote their chosen values. It follows that individuals should be

³ Medical need has been discussed in Chapter 2

allowed to behave in ways, which will be a risk to their health. Individuals are free to choose their own lifestyle provided that it does not interfere with the freedom of others: they can choose their own poisons and risks!

Nozick (1974: ix) makes this point in the introduction to his book: 'the state may not use its coercive apparatus for the purpose of getting some citizens to aid others, or in order to prohibit activities to people for their own good or protection.' In other words, paternalism⁴ is not justified and the state should remain neutral about what constitutes the good life. Libertarians would not accept coercive measures, but they should support the distribution of information and health education since this would facilitate individuals to make their own choices. Indeed, libertarians might argue that the state has a duty to provide relevant health warnings about the risks of smoking and poor diet, so that individuals can make decisions based on accurate information rather than myth or advertising campaigns.

In a society based upon the libertarian principles, as described by Nozick and Graham, there would be no state provided health care for those who became ill. It would not be significant as to whether the individual had contributed to their ill health by their adopted lifestyle. All those who became ill would have to rely on their own resources to pay directly or indirectly for medical treatment in the market place, or be reliant on charitable organizations or individuals.

In such a framework many people would contribute voluntarily to health care insurance schemes, which would probably be organized on a commercial basis. There is no doubt that premiums can be adjusted according to lifestyle. People who admit to

⁴ Paternalism will be discussed in Chapter 5. 6

horse riding, skiing, or smoking can be asked to pay a higher premium for the same protection offered to people who adopt a so called healthy lifestyle, or fail to admit to their bad habits! For those people who admit to smoking, higher premiums are already a reality. Physical attributes, such as obesity, which are associated with a certain lifestyle, can also be used to set a range of premiums. The libertarian would not object to this system because individuals would still maintain the liberty to choose whether to partake in the system or not. Since we may not be in agreement about which goods are valuable, people should be allowed to determine their own priorities and values, and any differences will not justify interference or coercion of others.

Libertarians are committed to the notion of value pluralism. There are many worthwhile and valuable lifestyles, goals, and relationships. While libertarians may allow smoking, drug taking and prostitution this does not mean that they endorse or welcome such behaviour. It is important to maintain the distinction between allowing certain activities and condoning or praising such actions. Hence the libertarian may permit smoking, overeating and a sedentary lifestyle, but may not approve of such behaviour. One can speculate that some libertarians might not be sympathetic to those individuals who had contributed to their ill health by their chosen pursuits, and consequently they might decline to offer help, preferring instead to give to those who were ill, apparently through no fault of their own. Libertarians are not likely to be sceptical about our ability to make voluntary choices and may hold individuals responsible for their behaviour.⁵ Others might favour a less judgemental approach, offering help where medical need and suffering were apparent, regardless of the causes of illness or injury.

⁵ Respecting liberty would hardly be attractive if people were unable to make choices for themselves and responded as mere puppets. Determinism and voluntary / involuntary choices will be discussed in chapter 4.

3.3 The socialist approach to justice.

The socialist account of justice does not accept the fundamental fairness of the market and the associated individualistic approach to the distribution of goods. Rather the socialist conception of justice takes equality to be the ultimate political ideal. Burdens and benefits in life should ideally be distributed according to the principle: 'From each according to his ability, to each according to his needs' (Marx and Engels 1992: 85). There are certain benefits, such as education, health and basic housing, which should be distributed according to claims of need, rather than in terms of cash payment, or any conception of social worth or merit. Socialist ideas are reflected in the welfare state and the recognition of the claims of need (Plant 1991: 186).

There are though, inherent weaknesses in an approach, which distributes benefits according to needs, both in the distribution of general goods in society and in the allocation of health care resources. Nell and O'Neill (1992: 93) criticise the statement 'From each according to his ability, to each according to his need' on three counts. Firstly, there is no guarantee, even if all contribute according to their abilities, that all needs will be met. Secondly, if all contribute according to their abilities there may be a material surplus after all needs are met. Finally, no incentive structure is evident. Why should people want to work hard, particularly at some unpleasant jobs in order to benefit others? The principle gives no guidance in situations of scarcity, when some needs must go unmet, or in situations of abundance when there is a surplus of resources. In addition, the approach does not present a method for assigning priorities amongst needs.

Marx visualized a society where abundance would be created and he insisted that the socialist principle of justice was applicable only in a context of abundance.⁶ One can

⁶ Contemporary writers such as Nell and O'Neill (1992) are in agreement that the Socialist Principle can only be implemented in the scenario of abundance

only insist that needs should be met when in practice they can be met. Nielson (1992: 105) states that his 'radical egalitarian principles are meant actually to guide practice, to directly determine what we are to do, only in a world of extensive abundance.'

In the scenario of health care provision, I have argued that there will always be potentially infinite health care needs and a limited financial budget.⁷ Rationing of health care resources is therefore inevitable, as we will be unable to meet all medical needs. The socialist principle of justice does not present any guidelines on how to prioritize needs and how to make decisions about which patient should be chosen for treatment, when it is impossible to treat everyone. Additional principles would be needed to differentiate between patients.

There is an additional weakness in any framework, which suggests that resources should be distributed according to need. As discussed in chapter 2, the scope of medical need⁸ is difficult to determine. Does cosmetic surgery or breast reduction meet a medical need? Such treatments may undoubtedly be of enormous significance for the individual, and can obviously contribute to psychological well-being. Indeed, refusal of cosmetic surgery or infertility treatment can drive a person to take drastic steps and possibly even to suicide.

In summary, the socialist approach to justice suggests that the allocation of health care provision should be according to the medical needs of the individual. Indeed the current NHS is based on the ideal that services should be available to every one on the basis of clinical need and free at the point of delivery. In reality, there are already certain exceptions in the provision of services on the current NHS, including dental care, infertility treatment, and cosmetic surgery, which are no longer widely available to everyone on the NHS. We cannot meet all medical needs and therefore difficult

⁷ Further discussion on the inevitability of rationing takes place in chapter 1. 4

⁸ Further discussion on needs takes place in chapter 2. 2

decisions will have to be made about which patients are treated, and which patients are not treated or kept waiting.

Is lifestyle a relevant criterion on which to allocate resources? From the socialist standpoint there is no obvious answer. In an ideal state of abundance, all patients who need care could be treated, regardless of their lifestyle. If you allocate resources strictly according to need, the cause of need is surely irrelevant and so it would not be significant as to whether the condition was self-inflicted or not.

In the current situation of limited resources, the socialist principle does not help us to determine whether it would be fair to discriminate on the basis of lifestyle. However, Nell and O'Neill (1992: 97) recognize that for certain questions about distributive justice, one might need to invoke a supplementary principle of distribution, which would have to be justified by separate and non-arbitrary arguments. This permits the notion of an eclectic approach where a variety of criteria, including lifestyle, might be used to determine who should receive treatment. It might, for example, be appropriate to delay treatment for those who are reckless and have contributed to their illness or injury, since they will contribute to the increasing need for health care. If desert were taken into account, it might help curb reckless and foolish behaviour and so reduce the demands on the health service.

3.4 Justice according to Rawls

In this section, I will present a brief outline of the theory of justice as presented by Rawls, and discuss the implications for the allocation of health care resources. I will explore whether this theory will provide any guidance for the central question of this dissertation: is it fair to ration health care resources partly according to previous lifestyle?

Rawls (1972) presents a comprehensive political theory, which structures our different intuitions according to three specified principles.⁹ The first principle of justice, the ‘Ideal of Liberty’ states ‘Each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all’ (Rawls 1972: 250). According to this principle, the government or authorities should not adopt coercive measures to change the behaviour, (including health-related behaviour), of individuals, if such measures conflict with the free choices of individuals. According to Rawls, individuals have priorities and values and will develop their own life plan with some idea of what they would like to be or what they would like to achieve. The principle of liberty will allow individuals to pursue their own chosen goals.

The second principle proposed by Rawls is known as the ‘Difference Principle’ and in essence, it advocates the ideal of equality for all citizens, except in certain specific circumstances. The principle states that ‘Social and economic inequalities are to be arranged so that they are ... to the greatest benefit of the least advantaged ...’ Rawls (1972: 302). Rawls accepts that there may be considerable differences in the ownership of various goods in any society; unequal distribution can only be justified providing that the disparities of wealth contribute to the greater benefit of the least well off.

⁹ Rawls proposes two principles, but the second principle is subdivided into two, so I will examine the three principles and their relationship with one another

Hence social and economic inequalities are justified if, and only if, they work to the advantage of the most disadvantaged in society. (Just how you identify who is the least well off is controversial).

The third principle is closely related to the difference principle and is known as the 'Principle of Fair Equality of Opportunity'. It states that 'social and economic inequalities are to be arranged so that they are attached to offices and positions open to all under conditions of fair equality of opportunity' (Rawls 1972: 302). This principle suggests that it is morally acceptable to have different rewards for different jobs and positions, provided that the competition for securing those positions is fair. Fairness requires that jobs should be allocated according to relevant differences between individuals, such as their qualifications and capacity to do the job. Differences such as sex, race, and ethnic background are not relevant criteria in the selection process for most jobs.

Any theory, which proposes a variety of principles, can potentially result in internal conflict. Rawls therefore imposes a system of priority amongst the different elements in his theory and proposes that the first principle of equal basic liberty must always take precedence; 'Liberty can be restricted only for the sake of liberty' (Rawls 1972: 302). In addition, the principle of fair equality of opportunity must take priority over the principle of equality of resources.

Rawls claims that these principles can be justified by their correspondence with those principles, which we would choose after considered moral judgement. He also claims that rational people, who are placed in the 'original position' of an imaginary society, would naturally choose certain principles of justice in order to maximise their share of primary goods. People, who are ignorant about their own conception of the good and their own skills and natural talents, behind the 'veil of ignorance,' will, according to

Rawls, naturally choose these principles. People would be concerned to protect their freedom of choice so that they would be able to pursue their own conceptions of the good; hence the first principle of liberty. In addition, Rawls claims, people who were ignorant of their own position in the distribution of social and economic advantages would ensure that the worst position was as good as possible. People would therefore choose a principle of equality, except in circumstances where inequality would benefit those in the most disadvantaged positions.

The 'veil of ignorance' is an intuitive test of fairness since it prevents people from promoting their own perception of the good or establishing a framework which will advantage their particular position, social circumstances or natural abilities. This approach to justice is modeled on the intuitive approach to justice and fairness which is often adopted with children: the one who cuts the cake does not know which piece he will receive, so that he cuts the cake as fairly as possible.

Rawls suggests that it is possible to identify a set of primary goods, which represent those things that a rational man would want regardless of his own life plan and goals. In a pluralist society, one can assume that people's life plans will differ and could potentially conflict. Nevertheless, Rawls (1972: 92) states: 'Regardless of what an individual's rational plans are in detail, it is assumed that there are various things which he would prefer more of rather than less.' Primary social goods are those goods, which are distributed by social institutions, and include rights and liberties, powers and opportunities, income and wealth, and a sense of one's own worth (Rawls 1972: 62). Rawls does not recognize health and education as primary social goods in themselves. Rather he proposes that health should be categorized as a 'natural good' in association with vigour, intelligence and imagination, because it is not directly controlled by the basic structure of society (Rawls 1972: 62). These natural primary goods are affected by social institutions but are not directly distributed by them.

While it is certainly the case that no amount of health care provision, or any structure of society, can guarantee health as such, medical resources can determine the opportunities that an individual can hope to expect. For some people who are dependent on medical care and drugs, it makes little sense to discuss liberty and opportunities if lifesaving treatment is not available. For those who require expensive and ongoing health care, the distribution of wealth and power will not be significant, unless their lifesaving treatment is available. I propose that a rational man might therefore wish to include lifesaving health care as one of the primary goods.

I have presented a brief summary of Rawls's theory of justice. I will now consider the implications of this theory for the distribution of health care resources. There are two key questions, which I wish to explore:

- (i) Should health care be traded in the market place like other commodities?
- (ii) Which principles of distributive justice regarding access to health care would be chosen by rational individuals in the original position?

Rawls focuses on the distribution of wealth and income in society and he does not explicitly discuss the issue of allocating health care between individuals. Rather Rawls (1982: 168) states that he has put this difficult problem aside and assumed 'that all citizens have physical and psychological capacities within a certain normal range.' He justifies this approach by suggesting that the fundamental problem of justice concerns 'the relations among those who are full and active participants in society' and that if a theory is established for the normal range, we can handle the other cases later (Rawls 1993: 272).

Rawls seems to assume that if wealth and income are fairly distributed, in line with his three principles, it follows that other commodities will be fairly distributed. In this system, health care provision is seen as one of many goods, such as computers and

cars, which individuals can purchase if they wish within the market place. In addition, individuals could choose to protect themselves against future costs of accidents and ill health, by contributing to voluntary insurance schemes at a level which they determine according to their own preferences and in relation to their own financial situation.

It is pertinent to ask whether health care should be viewed in the same way as other commodities, which we agree to buy and sell in a market place. Or is health care *special* so that it should be differentiated from other goods? While recognizing that health care is obviously a broad and diverse notion, incorporating various institutions and services, I suggest that health care generally meets a basic need for human beings. Health care is important and different from other goods because it promotes and preserves normal functioning and is fundamental to the future opportunities of each individual. If people are denied access to health care they may not have the same chances as those who are given medical care.

Norman Daniels (1985) presents this argument in his discussion concerning the macroallocation of health care resources. He suggests that health care provision is a special good, which should be distributed according to need rather than wealth, because it is fundamental to the provision of equality of opportunity. 'Impairment of normal functioning through disease and disability restricts an individual's opportunity relative to that portion of the normal range his skills and talents would have made available to him were he healthy' (Daniels 1985: 33). In this way, health care should be compared with education, which is also necessary for people to lead normal lives, and have a range of opportunities. This view that health care is *special*, and is not a commodity, which should be purchased solely in the market place, is reflected in the NHS ideology.

While Rawls does not include health care among the primary social goods and does

not distinguish it from other commodities, I would agree with Daniels that health care provision should be included within those social organizations, which help to promote fair equality of opportunity. Health care provision should therefore be considered as a special good and it should be distributed according to need rather than the ability to pay.

My second question is which principles of distributive justice, regarding access to health care, would the rational person in the original position choose? Even if the veil of ignorance is accepted as a device for determining what principles are fair, it is still not clear which principles would be chosen. Rawls suggests that the rational individual would choose the difference principle, but this can be challenged. Why should the rational individual choose a principle, which defines the worst off primarily in terms of income and wealth and makes no direct reference to people's natural goods such as intelligence, health or physical ability? According to Rawls, people can be equally well off provided only that they have the same 'primary social goods' and yet one person may be physically or mentally handicapped, or suffering from ill-health.

I suggest that health could determine our overall well being and opportunities in life to an equivalent or greater extent than our economic wealth. If we accept that health is fundamental to human welfare, the rational individual in the original position might wish to choose principles, which reflected the importance of health care. For example, a principle that distributed health care according to need and regardless of financial assets might be chosen. Similarly, the rational individual might wish to choose principles, which ensured education for all young people. It is by no means certain that the rational individual in the original position would choose the difference principle in preference to other principles.

From behind the veil of ignorance, individuals might assume that they would normally

be independent and able to manage their own affairs in society. Hence they opt for a framework which promotes individual freedom and choice. In the hypothetical contract, it is also probable that individuals would agree to certain protective measures for those individuals who were unable to make rational decisions and protect their own interests. For example, individuals who are immature, experience learning difficulties, or are affected by serious mental disease, should be protected against their own potentially irrational inclinations or weakness. The individual in the original position might accept paternalism in some cases so that others could act to override immediate irrational wishes of individuals in order to promote their best interests.

Rawls (1972: 249) suggests that paternalistic interventions should be guided by 'the individuals own settled preferences and interests insofar as they are not irrational, or failing a knowledge of these, by the theory of primary goods'. He proposes that we should be satisfied that if or when the individual recovers his rational powers he would accept the decisions made on his behalf. This future-orientated consent is not sufficient in itself because there must also be evidence that the individual is behaving irrationally or with weakness of will. Since Rawls gives lexical priority to the first principle of liberty, which enables individuals to make their own choices, it follows that paternalistic interventions will only be justified when the individual is no longer able to make rational decisions.¹⁰

I conclude that the rational individual in the original position might agree to certain paternalistic interventions. These might include current legislation, which enforces the use of car seat belts and motorbike helmets, and restricts alcohol and smoking for the young. Such measures will overcome the irrational short-term wishes of the individual or indeed a temporary lapse of memory! In a rational state of mind most people would accept such restrictions of their liberty. It is more difficult to know whether the

¹⁰ An individual who is able to make rational decisions, may choose not to. In this case, it would be justifiable for doctors, or others, to act in their best interests.

rational individual would agree to more intrusive restrictions in order to protect them from their own recklessness.

Finally, I will explore whether Rawls's theory of justice will help us to answer the central question of this dissertation: is it fair to ration health care resources according to previous lifestyle? Since Rawls's theory does not attempt to give specific guidelines for the allocation of health care provision between individuals there is no obvious answer here. However, the theory does not explicitly suggest that it would be unfair to discriminate against those who had voluntarily contributed to their own ill health.

Rawls (1972: 96) states that the primary subject of justice is the basic structure of society because its effects are so profound and pervasive and present from birth. His theory of justice focuses on the ways in which the major social institutions might regulate the inequalities, which affect people's life-prospects (Rawls 1972: 7).

However Rawls suggests that once his principles are satisfied 'other inequalities are allowed to arise from men's voluntary actions' (Rawls 1972: 96). So it appears that the inequalities which arise from people's voluntary choices are the individual's own responsibility. For example, when inequalities of income are the result of choices, either to work hard or to spend extra time on leisure, the individual has not been treated unfairly.

Rawls proposes that inequalities of birth and natural endowment are undeserved; (nobody deserves to suffer from a hereditary condition such as haemophilia, cystic fibrosis or low intelligence) and that these inequalities should somehow be compensated for. In essence, society must give more help to those with fewer natural assets to provide genuine equality of opportunity (Rawls 1972: 100). According to Rawls it is therefore justified to allocate more resources to those children who have learning difficulties or health problems.

It is pertinent to the central question of this dissertation that Rawls suggests 'undeserved' inequalities should be redressed to promote equality. This seems to imply that the individual can create a situation where he or she deserves different treatment. It follows that people who need liver transplants as a result of excessive drinking may not compare favourably to those patients who develops carcinoma of the liver through no apparent fault.¹¹

How would the rational individual, in the original position, choose to distribute limited health care resources? The rational individual would have to decide whether people were responsible for their health-related behaviour. Rawls promotes the principle of liberty and the ideal that people should be able to determine their own priorities. In so doing, he seems to assume that people can make choices for themselves. It follows that if individuals have *voluntarily* chosen to continue to smoke, overeat or drink excessive alcohol, with the knowledge of the risks to their health, then they ought to accept the consequences of their behaviour. It would therefore be fair to give priority to those people, who have maintained a healthy lifestyle, when it is impossible to treat everyone.

In addition, a system which allowed open access to health care for all, including the so-called 'undeserving' would not favour the prudent individual, who chooses to lead a healthy lifestyle, and resists the temptation of sloth and overeating. Indeed, prudent individuals who become ill through no fault of their own, might find that the limited resources had already been given to the 'undeserving'.

However, the rational individual might have some reservations about whether people really can make choices about their lifestyle. If people are unable to control their

¹¹ Further discussion on this topic will take place in Chapter 7

lifestyle and health related behaviour, then it is reasonable to choose a system whereby everyone has access to health care, irrespectively of whether they have maintained a healthy lifestyle or not.

In his theory of justice, Rawls does not discuss the issue of individual responsibility for health related behaviour. Daniels (1996: 198) also acknowledges that his own account of distributive justice in health is incomplete, because he has concentrated on social obligations to maintain and restore health and yet has ignored individual responsibility to do so. He states that there is nothing in his approach that is incompatible with encouraging people to adopt a healthy lifestyle but that hard questions still remain about 'how to distribute the burdens that result when people "voluntarily" incur extra risk and swell the costs of health care by doing so' (Daniels 1996: 198).

In summary, according to Rawls, individuals in the original position will choose those principles, which ensure the best possible access to the primary social goods, which will enable them to lead a worthwhile life. Rawls does not include health care as a primary social good, but I have proposed that health is fundamental to future opportunities, to an extent comparable to income and wealth. It is therefore possible that rational individuals might choose those principles, which gave everyone, the best possible access to health care. Rawls suggests that individuals are responsible for inequalities that arise from their own voluntary choices. This leaves us with a relevant question: Do individuals make voluntary choices about their health-related behaviour?

3.5 The Communitarian approach to justice

Contemporary writers such as Alasdair MacIntyre, Michael Walzer and Michael Sandel present an approach to justice, which recognizes the claims of citizenship and the community as a whole. They criticize the image of an independent and lone individual who makes choices irrespective of his or her roles and commitments in life. Rather, the communitarian approach to justice views individuals as part of the wider community and participants in a common life. The communitarian challenges the notion that individual rights should always have priority and suggests that sometimes they can be overridden, or limited, by appeals to the good of the community as a whole.

Various authors such as Bell (1993), Allen Buchanan (1989) and Amy Gutmann (1985) begin their account of communitarianism by assessing the liberal political philosophy. Bell (1993: 4-8) suggests that communitarian critics of liberalism make three general claims:

1. Liberalism rests on an overly individualistic conception of the self;
2. Liberals are insufficiently sensitive to the importance of community or social context;
3. Liberalism contributes to, or at least does not sufficiently recognise, the adverse effects related to the 'atomistic tendencies' of modern liberal societies.

I will examine each claim in turn and present the alternative communitarian approach. There is considerable debate in the literature about the limitations of liberalism, but the development and clarification of the communitarian ideas, and the implications for practice, are rarely made explicit. I will therefore present some tentative ideas about the implications of communitarianism for the distribution of health care resources.

Liberal theory implies that individuals choose their values in some kind of abstract

detached way and that individuals can determine their own personal destiny. According to Alasdair MacIntyre this perception of the self is mistaken because everyone is born with a past and each person has a particular historical and social identity within the wider community. 'The self has to find its moral identity in and through its membership in communities such as those of the family, the neighbourhood, the city and the tribe' (MacIntyre 1984: 21). Even those individuals who rebel against their identity are clearly affected by their past and current roles. Hence the self is 'embedded' in and at least partly constituted by the traditions, commitments and values of the community within which the person finds him or herself.

Liberals, such as Rawls, defend the notion of individual rights and suggest that the individual should be free to stand back and assess the available options and make independent choices; in this way the self is said to be prior to its ends. It follows from this vision of 'the self' that the state should establish a neutral framework where individuals can choose among competing purposes and goals to meet their own life plans. Individuals should not be penalised for different approaches to life. For example, unorthodox religious or sexual practices should be permitted, provided that they do not impinge on the liberty of others. The state should not therefore impose a particular vision of the good life, but promote an environment where individuals are free to pursue their own perceptions of the good.

Communitarian critics of rights-based liberalism argue that liberals exaggerate our capacity for self-determination and neglect the social commitments, which will limit our capacity for independent choice. Sandel (1982: 179) argues that we are not independent because we have allegiances and loyalties, which contribute to the particular persons we are. He writes that attachments 'to family or community or nation or people allow that to some I owe more than justice requires or even

permits, not by reason of agreements I have made but instead in virtue of those more or less enduring attachments and commitments which taken together partly define the person I am' (Sandel 1982: 179).

The second area of concern for the communitarian critics of liberalism lies in the importance of the social context of behaviour. Alasdair MacIntyre (1984: 208) suggests we cannot characterise behaviour 'independently of intentions, beliefs and settings.' Consider the example, presented by MacIntyre (1984: 206), of the man digging in the garden; this may fulfil a variety of different functions including gardening, taking exercise, preparing for winter, or pleasing the wife. While some of these answers characterise the agent's intentions, others are unintended consequences of the actions. We can only identify and understand what someone is doing when we place the behaviour in the context of the narrative history and the setting in which it occurs.

The notion that people are part of a wider community and that their behaviour will reflect the values and traditions of that community has interesting implications when applied to health related behaviour. According to the communitarian approach, the individual does not make decisions about health related behaviour in isolation. The act of going to the pub may reflect a desire to drink alcohol but the intention could also be to quench a thirst, socialise with mates, act in a manly way, or escape the wife! This example illustrates the point made by MacIntyre that everyone is under certain constraints; we enter a stage we did not design and we find ourselves in particular roles within an ongoing story. We should be wary of judging individuals as blameworthy if their behaviour is partially determined by the culture and traditions in which they find themselves.

The third claim made by communitarian critics of liberalism is reflected in the

statement made by Bell (1993: 7); 'There is undoubtedly a worrying trend in contemporary societies towards a callous individualism that ignores community and social obligations.' This is evident in the breakdown of family ties and communal commitments throughout the Western society today.

Communitarians, as interpreted by Buchanan (1989: 856), emphasise that a genuine community is not a mere association of individuals. Members of a community share common goals and values, and their interests are interdependent. It is claimed that the community is a fundamental good for human beings and they will benefit from their membership. Michael Walzer (1983: 65) claims that 'men and women come together because they literally cannot live apart' and they need each other for the communal provision of security and welfare. But more than this they need the community itself, with its associated 'culture, religion and politics' (Walzer 1983: 65) in order to recognize and agree on what goods are necessary for the common life.

Walzer emphasizes that communities will differ from each other, because there will be different experiences and different environmental challenges. The community will determine its own patterns of provision for security and welfare and identify its own priorities. Views about what constitutes a good for the community will be embodied in the ways of life of that particular society. Communitarians do not accept the notion of the neutral state, and argue that a political framework, which supports the common good as perceived by the community as a whole, should replace it.

One would therefore expect to find different policies governing the provision of health care in different societies. The NHS in Britain was initially based on the aspiration to provide health care to 'every citizen, on the basis of clinical need, regardless of ability to pay' (Department of Health 1992: 4). In contrast, provision in the USA reflects a system of free enterprise in medical care and Walzer (1983: 89) claims that 'individuals

will be cared for in proportion to their ability to pay and not to their need for care'. The so-called safety net and communal provision is made available for the very sick and old, but at a level where poverty can lead to inappropriate and inconsistent care.

According to the communitarian view, members of the community should come to an agreement to redistribute the available resources based on a shared understanding of their needs. People's sense of what they need will reflect the values of the society and the prevailing culture and knowledge of the time. In essence, communitarians express a commitment to collective values and the promotion of the overall good of the whole community. If a community values the principle of liberty - the libertarian ideal – then they may not agree with blanket public health provision, but prefer to allow individuals to determine their own priorities.

Having discussed the main communitarian ideas, I will examine the implications of adopting a communitarian approach to the distribution of health care resources. Many of the so-called communitarian writers do not discuss the implications of their approach to the allocation of medical resources. However, MacIntyre (1992: 245) criticizes the distribution of resources in the United States claiming that there is a horrifying level of infant mortality, which results from continued deprivation. In addition, he claims there is evidence of inappropriate care for the elderly where resources are increasingly directed to 'the mindless extension of the length of human life by medical science into a more and more mindless old age' (MacIntyre 1992: 246).

In attempting to address questions about the distribution of general goods in society, Michael Walzer (1983: 84) defends three principles:

'that every political community must attend to the needs of its members as they collectively understand those needs;

that the goods that are distributed must be distributed in proportion to need;

and that the distribution must recognise and uphold the underlying equality of membership.’

While Walzer suggests that these principles are relevant to the entire sphere of welfare and security, there are some problems when they are applied to the realm of health care. The fundamental ideals of the NHS in Britain recognize that resources should be allocated according to medical need and that all citizens of the community are entitled to certain health care, regardless of ability to pay. On the face of it, this seems to be compatible with the principles as proposed by Walzer. However there are still several difficult questions to answer. What precisely is a medical need as understood by the members of the community? British society is made up of a variety of different cultures, which have different priorities and may not be able to come to a consensus as to precisely which needs should be treated. In a pluralist society there will almost certainly be conflict as to which medical needs should be met and Walzer offers no mechanism for arbitration. In addition, there are no guidelines as to how to decide which patient should be offered treatment when not all patients, with similar needs, can be treated because of limited resources.

Secondly, who exactly are the members of this society? Should membership include early embryos, very premature babies, or those who are in a persistent vegetative state? At the risk of appearing callous and mean, one could question whether certain human beings might be excluded from ‘membership’ because of their medical condition. In addition, the NHS may exclude people from foreign countries, unless they are prepared to pay for the financial costs of treatment.

The three principles as proposed by Walzer are not therefore as helpful as appears on initial examination and questions about the distribution of medical resources remain. There are however some general ideas, which could generate areas of priority. In

essence, I believe that the communitarian would have to ask what type of provision and distribution of services would benefit the community as a whole. I suggest that the emphasis from a communitarian perspective should be towards public health measures to maintain and improve living and environmental conditions for society generally. Initiatives which aimed to prevent pollution, maintain a safe and appropriate food supply, and provide reasonable housing for all the population should improve the general health and well being of all the members of the community.

Such initiatives might involve coercion and could limit the freedom of certain individuals but the overall good to the majority would override any supposed rights of the individual, according to the communitarian. Consider the hygiene regulations which are imposed on food producers; such regulations can force producers to adopt certain standards of hygiene, and potentially reduce profit margins, in order to protect the general public and promote the good of the community as a whole.

The ancient Athenians, according to Walzer (1983: 67), provided public baths and gymnasiums for the citizens in preference to social security or free medical services. This presumably reflects the limited knowledge of medicine at that time. Nevertheless, the gymnasiums may have encouraged individuals to take regular exercise with an associated improvement in their general fitness and well being. One could speculate that such provision today would also result in improved health and would be a justified use of available funds, if the community agreed that such provision met their overall welfare needs. The vast amount of financial resources allocated to intensive care beds or cots, which will benefit only a minority of the community, could perhaps be used to provide a greater good for the whole community, if they were allocated to sports facilities.

Health education and health promotion programmes, which could be shown to

improve the health of the community, would also be a priority. The emphasis on maintaining health and preventing illness would be a good for the whole of society for a variety of reasons. If members of society remain healthy they can contribute positively to the overall good in terms of productivity at work, but also in sustaining family bonds and commitments.¹²

It seems reasonable to accept that early death is usually a harm both to the individual and the community. It is, therefore, relevant to ask whether the communitarian would restrict high-risk behaviour, such as smoking and parachute jumping, either by coercive measures or total prohibition of certain activities. While the liberal approach to justice will emphasize that individuals should be free to choose their own behaviour in relation to their own priorities and life plans, the communitarian approach might accept collective strategies to prevent early death and accidents.

Of course, there are already coercive measures in the form of legal restrictions which limit or prohibit certain behaviour: motorcyclists must wear helmets, car passengers must wear seat belts and drivers can only drink limited amounts of alcohol. The communitarian, I believe, would support this legal coercion because of the resulting good for the community. Such restrictions do not impose unbearable burdens on individuals and are generally welcomed by members of the community.

Collective strategies could be extended to control the production of alcohol and tobacco so that such substances were not legally available to the public. Individuals would therefore have no choice as to whether they legally partook in the associated activities, and there might be a reduction in the number of premature deaths.

However, these substances are associated with pleasure and relaxation, and many people enjoy the effects. The communitarian would emphasize that the community

¹² Further discussion on health education will take place in chapter 5. 2

should agree on the common good and it seems probable that members of the community would not currently agree to a complete ban on alcohol and smoking. In addition, banning a pursuit may make it more attractive to the rebellious and prohibition may be ineffective in practice.

The central question of this thesis is whether lifestyle would be a morally justifiable criterion on which to allocate health care resources. The communitarian approach to justice does not present an obvious answer. Coercive measures¹³ (if needed and effective) and litigation to change the health related behaviour of individuals could be justified on the basis of a collective response to promote the health and welfare of the community. Rather than looking at arguments for and against paternalism and the interests of individuals, the communitarian will consider the commitments, interdependencies and shared concern for the well being of the community as a whole.

Communitarians may feel justified in exerting pressure on members of society to improve their health in order to promote the interests of the community as a whole. They may also feel obliged to look after those individuals who fail to overcome bad habits and subsequently become ill and in need of care. It would be a strange community, which failed to offer assistance to those members who had medical needs, regardless of whether these needs resulted from so-called self-infliction or bad luck.

I conclude that the communitarian approach to justice does not help us to answer specific questions about the allocation of health care resources between different individuals. It is however, relevant to note that the communitarian view does not explicitly suggest that it would be unjust to use lifestyle as a criterion in the allocation of health care resources.

¹³ Further discussion on coercion will take place in Chapter 5. 4

3.6 Conclusions about distributive justice and the allocation of health care resources

I have described four different theories of distributive justice and examined their implications for the distribution of limited health care resources. Each theory appeals to different ultimate values and establishes its own set of priorities. None of these theories suggests that taking lifestyle into account when allocating scarce health care resources must be unjust. In this conclusion, I will discuss how these contemporary theories might help us to determine what would be fair or just in the distribution of scarce medical resources between different individuals.

Many of the liberal writers of today, such as Nozick (1974), Graham (1988) and Rawls (1972) emphasize the importance of a framework in society which allows individuals the freedom to pursue their own good, to an extent which does not infringe the freedom of others. In this respect, liberalism does not make assumptions about conceptions of the good life or what is valuable; rather it suggests that there are many different worthwhile goals and relationships in life. Liberalism is therefore committed to the notion of moral pluralism and is based on a principles, which will be neutral between different conceptions of the good.

Graham (1988: 103) suggests that health is an 'evaluative term,' which embraces a variety of different physiological and mental states, and is perceived and understood by individuals in different ways. For example, athletes and ballet dancers may have different expectations, priorities and goals concerning their health from philosophers and ninety-year-olds. He compares health with the concept of fitness and proposes that fitness is not an absolute physiological condition in itself, but rather a relative term. What is fitness for Steve Redgrave is quite different from what is fitness for the average person and it is necessary to qualify levels of fitness with a further statement about fitness for what.

If people have different values in life, there is no reason to suppose that they will always wish to promote their health, rather than enjoying other competing values, such as the pleasure of horse riding, parachute jumping, sunbathing or over indulgence with excessive alcohol and good food. These activities are often valued, and chosen, despite the known risks to health.

Liberals emphasize that health is one value amongst many others, which individuals may choose to pursue, and that society should allow people to make their own choices about their behaviour. Accordingly the state is not justified in imposing a framework of uniform health regimes for all, or in coercing individuals to forgo a particular lifestyle which endangers health. It follows that health care professionals should usually allow people to make their own choices about health and refrain from imposing their own conception of the good. It would seem that doctors and nurses have a duty to inform people of the potential risks of their behaviour, so that people can make choices based upon accurate information.

The principle of respect for individual liberty is relevant to the central question of this dissertation: Should individuals sometimes forfeit future health care if they knowingly choose to adopt certain unhealthy behaviour? According to liberals, individuals should be allowed to adopt a lifestyle, which reflects their own values and priorities, provided that this does not infringe the liberty of others. Smoking, drugs and risky sports, such as boxing, are therefore permitted. Graham (1992: 35) concludes that ‘any decent legal system must allow the individual moral and religious freedom, and this includes the freedom for moral and religious error.’

However, if individuals adopt an unhealthy lifestyle they cannot assume that others in society will be prepared to care for them or pay for medical care. If the liberal approach to justice allows people the freedom to choose their own priorities in life, it

follows that it would be wrong to coerce people into paying or supporting a uniform health service for all. People might voluntarily wish to give money or assistance to help those with medical needs, but a compulsory system of taxation would not be justified. We might also speculate that people might be more willing to support those who become ill through no fault of their own, rather than those who had contributed to their ill health or injury.

The second idea to emerge from this survey of four contemporary approaches to distributive justice is the communitarian notion of the importance of the community. According to this view, individual rights, including the right to individual freedom, can be overridden for the good of the community as a whole. This has important implications for the distribution of health care resources.

Consider the treatment of infectious diseases: individuals who have notifiable diseases, such as tuberculosis, forfeit the right to make certain choices about their treatment and may also be restricted in certain forms of employment. Similarly, surgeons who contract the HIV or hepatitis B virus will not be permitted to continue performing surgery while they remain infectious and a potential risk to other individuals and the community. Individual freedom is also restricted for the sake of the community in compulsory immunisation programmes. Individuals are not offered a choice, but must provide evidence of current vaccination against certain diseases in order to travel. For example, a tourist might need evidence of a cholera vaccination before being allowed to travel to India. In each case, the coercion is justified on the grounds of the good of the wider community.

The communitarian approach to justice would seek to reduce the incidence of premature death and morbidity in the community. It seems probable that the promotion of health for the members of the community would be perceived as a

priority and a general good. Health promotion and prevention of disease and accidents would therefore be a priority. In addition, the communitarian might encourage people to adopt a healthy lifestyle and avoid known risks in order to reduce the financial costs of health care that the community will have to bear. Finally, the community might agree to legal restrictions to limit certain high-risk behaviour, even if this resulted in the loss of individual freedom.

The liberal and the communitarian approaches to justice appear to be in conflict with each other. Liberal theorists have sought to develop a framework, which acknowledges moral pluralism and refrains from imposing a vision of the good upon citizens. In contrast, the communitarian might seek to minimize ill health and the incidence of premature death in order to maintain the commitments and relationships, which are so important in any community. I suggest that a balance between protecting private choice and between promoting the common good and welfare of the community as a whole should be sought.

The distribution of health care resources is a complex and multifaceted process and it is unlikely that any one principle alone should guide our actions. I conclude that individual freedom should be permitted, but can be justifiably overridden for the good of the community in certain situations.¹⁴ This conclusion does not provide a neat and conclusive framework; rather it means that health care professionals, and other people who are faced with decisions about the distribution of health care resources, will have to consider both individual freedom and the good of the community.

Finally, I return to the central question of this thesis: Is lifestyle a morally relevant criterion on which to ration scarce medical resources? I conclude that this review of four contemporary approaches to distributive justice does not suggest that it would be

¹⁴ If an individual develops an infectious disease, such as open tuberculosis or hepatitis B, the liberty of the individual may be restricted in order to protect others in the community.

unfair or unjust, in principle, to discriminate against those individuals who adopt unhealthy lifestyles.

Further questions should be explored in order to determine what would be fair to different individuals. For example: do people make informed and voluntary choices about their lifestyles? Are people responsible for their health-related behaviour? Should they be blamed if they take risks and subsequently need health care? If so, who is in an appropriate position to make this judgement fairly? Can a policy, which discriminates against individuals who adopt unhealthy lifestyles, be implemented in a just and workable way?

Chapter Four

INDIVIDUAL RESPONSIBILITY

- 4.1 Does determinism make nonsense of accountability?
- 4.2 Individual responsibility
- 4.3 Voluntary and Involuntary behaviour
- 4.4 Responsibility for our former selves
- 4.5 Unhealthy behaviour – justification and excuses
- 4.6 Should we blame people for their unhealthy lifestyle?

4.1 Does determinism make nonsense of accountability?

Prior to any discussion about individual responsibility and whether we should blame people for their former lifestyle, I wish to say something about the notion of determinism and free will. If determinism is accepted, any further analysis of individual responsibility may be fruitless. Determinism,¹ as described by Honderich (1993: 6) implies that somehow we are not responsible; our choices and decisions are not free and what gives rise to them are merely causes, over which the individual has no control. Individuals change, or fail to change, their behaviour owing to what happens to them or in them, but they are unable to choose other than as they do, given their history and circumstances.

However, if people do not have individual free-will, and could not have acted other than as they do, it surely makes a nonsense of praising those people who act in a good way or conversely blaming those who fail to do so. Yet, we do offer praise and apportion blame according to how people behave. We congratulate the person who has given up smoking or lost a stone in weight (not often the same person) and we blame drunk drivers and hold them legally and morally responsible for their behaviour. In addition, we feel guilty if we eat the extra cream bun and may feel proud of ourselves if we resist the temptation. The fact that we do this does not show determinism is mistaken, only that we do not seem to believe in it.

The total elimination of voluntariness from our understanding of human behaviour would have implications for both applied ethics and public policy. Machan (1993) has argued that free will is a necessity presupposed in applied ethics: human beings can cause some of what they do, and their actions do not result solely from previous events or factors, which have influenced them. The range of options, which may be chosen by

¹ The debate about determinism and freewill has been discussed by Glover (1970), Honderich (1993), Lucas (1993) Chapter 2, and Ayer 1982: 15-23 amongst many others.

individuals, is clearly limited by their particular circumstances, education, talents and physical capacities, but even so they can make choices, from a varying number of options. Indeed, the assumption that people can make choices is evident in many professional codes, which guide doctors, nurses, scientists and others to conduct themselves in certain ways and to abstain from various activities. Professionals are seen to be accountable for their actions and praise or blame will be apportioned according to whether such guidelines are implemented.

Likewise, public policy, which attempts to influence the behaviour of people, would be questionable if individuals have no free will. If people are simply unable to change their behaviour, and have no power to originate choices or decisions, we should review the process of health education. It would seem that health promoters should concentrate on trying to change the environmental circumstances in which people find themselves, rather than focus on the individual. Some people certainly find it difficult to change their behaviour: - "I just can't stop smoking!" Others certainly experience great difficulty in breaking their habits, but there are many others who do respond to information and an increased understanding, persuasion and the offer of rewards, as they successfully give up smoking or other unhealthy habits. In such cases we offer praise and congratulations, because we assume that these individuals have made a choice and shown strong will power in changing their behaviour.

Graham (1992: 31) describes compatibilism as the acceptance of both freedom and causality, which is to say there is nothing contradictory in describing an action as both free and caused. A choice is free if you are acting as you wish, and yet what you want may be the result of external factors that have made you the person you are. Free will allows us to behave according to our desires, so that if I wish to eat the cream bun, I do so. Alternatively, I may choose to delay eating the treat until later, perhaps after some strenuous exercise. According to this view, freedom is a consciousness that we

are able to modify our behaviour and make deliberate choices, which is reflected in the control that we sometimes feel able to exert over our behaviour. Nevertheless, our desires may be predetermined and a result of external causes and past experiences; they are not static and may be modified by praise or blame. In essence, the compatibilist accepts that people are morally responsible for some of their actions, even though factors, beyond their own control, may have determined the desires of each person.²

It is beyond the scope of this dissertation to expand on the complex debate concerning determinism and whether it is compatible with the notion of free will. In the following discussion about individual responsibility, I will assume that individuals do have the power to originate choices and decisions even if their choices are sometimes limited by the circumstances in which they find themselves. This is reflected in the praise, blame, pride, and guilt, which we attribute both towards others and ourselves.

² This account of compatibilism is consistent with Hume's view, where liberty may be understood as compatible with determinism, if it is the liberty to act in accordance with one's desires. One can be free in this sense even if the desires are themselves caused by influences independent of one's own will.

4.2 Individual responsibility

Recent government policy and consultative documents³ recognize that the causes of ill health are complex, embracing some factors that the individual cannot control, such as the environment, genetic makeup, and aging. However, these documents emphasize that lifestyle also has an important impact on health. Diet, physical activity, smoking, alcohol, sexual behaviour and drugs are factors, which ‘can have a dramatic and cumulative influence on how healthy people are and how long they will live’ (Department of Health 1998: 20). It has become increasingly apparent that disease and illness are not merely the result of bad luck or fate, but that in some cases individuals may have contributed, by their choices, to the development of their own poor health and associated need for health care.

For example, individuals who choose to jump out of a plane with a parachute for charity may be injured on landing, and it would seem that there is a clear relationship between their chosen behaviour and their subsequent injury. Likewise, those individuals who adopt an unhealthy lifestyle, smoke, eat excessively and/or take no exercise, have increased their chances of becoming ill. It therefore appears that people’s actions are partly causally responsible for increasing the risk of subsequent illness, and their associated need for health care.

Nevertheless, people who adopt unhealthy lifestyles and/or partake in dangerous sports do not choose or intend to become ill or injured. Rather they hope that they will be the lucky ones who do not need subsequent health care. There is an element of chance, or luck, as to who will become ill or injured. Walker (1997: 39) illustrates this point with the example of a negligent or intoxicated or distracted surgeon who is unfortunate enough to injure a patient. She suggests that there is a large element of chance in

³ See Department of Health (1998) *Our Healthier Nation*; Department of Health (1997) *The New NHS Modern and Dependable*

meeting up with the precise circumstances which will lead to this dreadful outcome. Indeed she observes that several other equally negligent, intoxicated or distracted surgeons may be fortunate enough to avoid harming their patients.

In this chapter, I will examine a series of related questions. Firstly, assuming that people do by their habits, lifestyle or sporting pursuits sometimes contribute to their illness, is this aspect of their behaviour voluntary? Should we be held responsible for our former selves? Can unhealthy or risky behaviour be justifiable (not wrong) in certain circumstances? Can individuals present various excuses to explain why they should not be blamed even though they knowingly took risks? ⁴ Are those people, who voluntarily choose to take known risks with their health, blameworthy in principle? If yes, should they be punished and if so, is it appropriate to punish these people, by withholding treatment?

⁴ Austin (1961) *A plea for excuses*

4.3 Voluntary and Involuntary Behaviour.

If people adopt an unhealthy lifestyle, is this behaviour voluntary? Aristotle (1976: 115) suggests that 'a voluntary act would seem to be one of which the originating cause lies in the agent himself, who knows the particular circumstances of his action.' He argues that people should only be praised or blamed for their actions when such actions are voluntary. In contrast, involuntary actions are pardoned and sometimes receive pity (Aristotle 1976: 111). If unhealthy behaviour is involuntary, it should not be associated with blame.

Our attitude to certain lifestyles and behaviour may be partially determined by whether we believe the individual has made a voluntary choice in adopting the behaviour or has had little or no control. While passengers who are injured in a car accident cannot be blamed, (unless they have deliberately distracted the driver), we might attribute blame to those adults who take needless risks, and for example, drive too fast. This may be evident today in certain unsympathetic attitudes towards people with conditions such as lung cancer, liver cirrhosis, or A.I.D.S., which are sometimes associated with particular lifestyles or habits. Blame may be attributed to people who are thought to have made choices that have contributed to their own ill health. This attitude was evident in the original Oregon ranking of diseases, where treatment for cirrhosis of the liver without mention of alcohol was judged significantly more important than treatment for 'alcoholic cirrhosis of the liver' (Honigsbaum 1992: 34). It has also been apparent in recent British pilot studies by Williams (1992: 10-11), where people questioned were prepared to discriminate against those who had 'not taken much care of their health' when it came to distributing health care resources.

Aristotle (1976: 126) suggests that both virtues and vices are voluntary, because they are, to some extent, under our control and we have some independence in the choice

of our actions. It would seem to be our choice as to whether we eat the extra chocolate or resist and attempt to become more prudent in our appetites. If we really want to become thinner, and fit into the smaller outfit, it appears to be within our control to continue the reducing diet, or alternately abandon the diet and live with the consequences. We blame ourselves if we eat the extra cake, knowing that we have succumbed to temptation and it would be better for our health and appearance if we demonstrated greater resistance and prudence. Hence Aristotle (1976: 124) suggests that some people sometimes voluntarily incur physical defects and we blame them for it. We should not blame those people who are naturally ugly, but we may feel differently about those who become obese and unattractive, as a result of lack of exercise and/or over indulgence.

Kenny (1978: 27) states that every voluntary action must be an action that is in some sense wanted by the agent, in contrast to an involuntary action which is not necessarily desired. A person may be physically compelled to move; for example, his hand is pushed forcefully against the door against his wishes, and this would not constitute a voluntary action. However, Kenny recognizes that for many actions there will not be a distinguishable mental process when a deliberate choice is made; rather we perform many actions without conscious thought. These are choices, which are subject to the agent's will in the negative sense because he or she could have chosen to act otherwise. Blinking appears to be an involuntary movement, which occurs independently of any decision making process, but which the individual can usually alter intentionally if he / she chooses. When we drive a car, or play tennis, many of the actions seem to be automatic, and we do not deliberately choose each move. Nevertheless, we could choose to drive in a different way or decide to play tennis with our left hand if we needed a challenge.

Aristotle (1976: 111) illustrates the difficulty of distinguishing between voluntary and

involuntary behaviour with the example of the sailor who jettisons his cargo in bad weather. Normally people do not throw away their property, but if it were to save your life and the lives of the crew, it would seem to be a reasonable choice to make. This is a voluntary choice, because at the time of throwing the cargo overboard there is an element of choice, and the captain has the power either to act or not. In the dire circumstances, throwing the cargo overboard is what the captain wants to do. However, he may have acted unwillingly, and regretfully, knowing that the loss of cargo is serious. His decision is clearly influenced by external factors and he can only choose from a limited number of options. In such a case, the agent did not intentionally create his limited options and we should recognize these restrictions, when judging his actions. It will be true to say that the sailor chooses to jettison the cargo, but it would be misleading to say this without qualifying the statement and mentioning the restricted alternatives which were available to the agent. 'What he does intentionally is not just X, but X-rather-than-Y' (Mackie 1977: 205). In essence there can be no genuine freedom in the absence of the power to do otherwise; 'a person acts freely when he does X only if at the relevant time he can abstain from doing X' (Kenny 1978: 29). In addition, in order to do X freely one must have both the ability and the opportunity not to do X.

A contemporary analogy to Aristotle's sailor is the hospital manager who chooses to sack thirty employees, supposedly in order to save the trust from debt. There may be limited choices in this scenario and yet the manager is still responsible when he or she chooses this option rather than any of the alternative options. He or she has made a voluntary choice, albeit unwillingly in some cases because the options were restricted. When appraising these actions we should recognize that the choice was from a limited number of options, which may sometimes excuse the manager from criticism or blame. While the manager is responsible for the decision, which is made, she/he may not be responsible for the limited choices available in the situation.

Of course, it is possible that the agent is responsible to some extent for being in a predicament where choices are limited. For example, if the sailor was warned of bad weather, but still put out to sea, he might be partly responsible for his limited choices. Similarly, the manager may face stark choices now because she / he did not invest in appropriate staff development or budget management.

Adults usually make voluntary choices about their lifestyle, even though the options may sometimes be limited, and their family and upbringing may have influenced them. Eating a healthy diet will clearly be dependent on the availability of reasonably priced fresh fruit and vegetables, and it may be difficult for those who are on a low income if the healthy choices are the most expensive. However, people do choose their own diet and choose whether to partake in risky sports. They might therefore be held to account for their lifestyle, if they are unable to justify or offer an explanation for their behaviour.

Some patients have health care needs, which follow involuntary behaviour. The patient who arrives at casualty following an epileptic fit, with a head injury, did not desire the outcome and was not in control of his/her actions. Yet, even involuntary behaviour may sometimes be blameworthy and may leave us with some questions: Did the patient take his/her prescribed medication? Should the patient have known about the risks of non-compliance? Some ignorance may be culpable: consider doctors or midwives who have a statutory requirement to keep their professional knowledge up to date since their practice must be based on relevant research and information. It would be no defence in law, or morally, to say that they were ignorant of the recent research and therefore blameless.

Aristotle (1976: 111) suggests that we should not be blamed for involuntary acts, which he classifies as those which 'are performed under compulsion or through (non-

culpable) ignorance.’ Is the individual who smokes or takes recreational drugs making a voluntary decision or responding to compulsion, because of an addiction? It is well documented that regular use of both nicotine and certain drugs will result in physiological changes in the body, which may drive a person to seek more of the same drug. Accordingly, the choice of one who has acquired an addiction should be classified as an involuntary choice, and we should not blame the individual for the associated behaviour.

However, when the individual starts smoking or taking drugs, the first choices might be classified as voluntary, and therefore might merit blame. There is an element of doubt here because in many cases of smoking and drug use, the individual may be immature, or be unaware of the reality of the inherent health risks. I am not suggesting that many young people today are ignorant of the risks of smoking itself, but it seems plausible to suggest that they may genuinely believe that the risks of ill health will not affect them. Even if they know the statistics for smoking and related illness, it is possible that they disassociate such figures from themselves, believing that the risks are for the middle aged and old, rather than the young. Alternately, they may be confident that they will be able to quit smoking later, as many people do. It is difficult to say with confidence that people, who voluntarily smoke and/or take drugs, understand the risks. We should therefore be cautious about attributing blame to those individuals who partake.

There are difficulties in trying to determine whether the behaviour of particular people is voluntary or involuntary. Consider those people, who know that continued overeating, and too much chocolate, will increase the subsequent risk of obesity and ill health. They may be keen to give up chocolate for the long-term benefits and improved health, but be unable to resist the temptation of just one more chocolate today. If these individuals are genuinely unable to resist this temptation, then the

action should be classified as involuntary, even though, in one sense they are doing, as they want. To be voluntary, it must also be the case that they could do otherwise. It is of course difficult to know whether individuals are unable to do other than they do. Some characters may be unable to resist the temptation, and cannot help themselves, whereas others are more able to control their short term desires.

4.4 Responsibility for our former selves

Parfit (1986: 124) examines our attitudes to time and suggests that it is extremely common for individuals to care more about the nearer future, than the distant future: 'Someone with this bias may knowingly choose to have a worse pain a few weeks later rather than a lesser pain this afternoon.' However, he suggests that it is irrational to care less about future pains just because they will be in the future. The concern is not less because of some intrinsic difference in the object of concern - the pain itself - but 'because of a property which is purely positional, and which draws an arbitrary line' (Parfit 1986: 126).

Nevertheless, it is apparent that many people will succumb to the immediate temptation, making a voluntary choice to eat excessively or smoke just one more, rather than adopting a healthy lifestyle, which will reduce the probability of future illness and suffering. It may be difficult at times to resist and even uncomfortable to decline the cigarette or extra drink, but the future pain may be significantly worse.

Parfit explores the motivational makeup in which the individual discounts pleasures and pains that will occur on future Tuesdays (1986: 124). If one is future Tuesday-indifferent, one will accept the prospect of great suffering that will fall on a future Tuesday in order to save oneself any amount of suffering now. When Tuesday actually arrives, the individual reacts to both pain and suffering in a normal manner, but there seems to be a lack of prior recognition.

Parfit's theory on personal identity may provide a possible explanation for this indifference to future pains. According to Parfit (1986: 319) a person's life could be subdivided into a series of successive selves, known as person stages. Personal identity through time is constituted by psychological links that connect later to earlier person

stages. The identity of a person is not in itself morally significant; rather it is the psychological continuity and 'connectedness' that matter. So the elderly person may not be the same person as the carefree child, although there may be some psychological links that connect the various stages of the life. These links would include memory, persistence of beliefs, and perhaps continuity of personality.

Generally the connectedness will become weakened over time and sometimes it can be severely weakened by physical or emotional trauma such as a head injury, stroke or nervous breakdown.

If the psychological continuity is sufficiently weakened, it is possible for an individual to feel that their earlier life was alien and they may fail to identify with that earlier self: it may feel like a different person. However, if one feels alienated and ashamed of former behaviour, it implies that one does realize that the former individual was oneself.

Parfit suggests that we may also feel alien to our future selves: 'If we now care little about ourselves in the further future, our future selves are like future generations' (Parfit 1986: 319). Parfit asks us to consider a boy who starts to smoke, without much concern that this may cause cancer in the future. If this boy does not identify with his future self, we might argue that his attitude to this future self is in some ways like his attitude to other people. He will therefore harm another by his action of smoking. This suggests that smoking is morally wrong because it may impose a premature and painful death on another. Hence Parfit writes that 'great imprudence is morally wrong. We ought not to do to our future selves what it would be wrong to do to other people' (Parfit 1986: 320).

Lockwood (1994) does not agree with Parfit's claims about personal identity. Rather Lockwood believes that personal identity does matter and is more than psychological

continuity and / or connectedness between person stages. He suggests that there is a relation between the earliest action and awareness of the developing foetus (in the womb) and the doings and experiences of the adult. They could be counted as the actions and experiences of the same person.

It follows that elderly people, who have committed a crime in youth, or have been imprudent during their early years, cannot escape the sins of their youth. They remain responsible and accountable because they are the same person. However, Lockwood (1994: 74) does point out that forgiveness is still possible: those who committed the sins are, in a morally relevant sense, still there to be forgiven. He does not therefore imply that they should necessarily be punished for former sins or imprudence. Indeed, we might not blame people for their former behaviour as immature adolescents, and accept that they have subsequently learnt from their mistakes.

It is not obvious which view of personal identity we should accept. The notion of person stages as discussed by Parfit, does appear to reflect the idea that in life we do sometimes dissociate our present selves from our former selves. Our lifestyle and behaviour may change drastically. Nevertheless in reality, we do blame people, and ourselves, for their former behaviour and if people change their behaviour for the better, we give them credit: the alcoholic, who reforms surely deserves our praise, and it would be strange to suggest that the former drunkard was someone else. We make lifelong commitments to particular individuals and we hope to keep to our obligations, even though we know that they will change over the years, we still identify them as the same people. We plan for our futures and invest in insurance policies to ensure a financially secure future. While we may accept that people move through various stages of life, with different roles and priorities, they remain the same people, so that they may be held responsible for their former selves.

4.5 Unhealthy behaviour – justification and excuses

Even if individuals have contributed to their disease and need for health care by their own voluntary behaviour, their behaviour may still in some cases be justified. In the particular circumstances of the situation, it may be right to take risks with health in order to fulfill other competing obligations. For example, the fireman or parent will try to rescue the child from the danger of a fire, knowing that there is a great risk to their own health. In a similar way, the sea captain may jettison his cargo in the storm in order to save the ship and crew. This behaviour is justified in the particular circumstances and we may offer praise and congratulations accordingly.

However, for the majority of individuals who adopt an unhealthy lifestyle and take known risks with their health, the behaviour cannot be justified because of competing obligations. Individuals who choose to indulge in smoking, overeating or dangerous sports may however offer a variety of excuses to explain their behaviour and defend their conduct. They will admit that their behaviour was wrong, indulgent, and weak-willed, but claim that it was excusable: there were extenuating circumstances, which explain, to varying degrees, why they acted as they did.

For example, people might claim that they were conforming to group pressure – everyone was drinking and others unduly influenced them. Alternatively, teenagers may agree that they were drunk and disorderly, but plead that they did not understand the true content of their drink and the effects of alcohol. By drinking excessively, the teenager may cause an acute episode of illness, but it would be wrong to attribute blame, if the individual did not understand the risks. In each case, the defence rests on a fuller description of the event and the context of the behaviour, which may explain, either fully or partly, why people behaved as they did.

Austin (1961) suggests that in most cases, justifications can be distinguished from excuses. He uses the example of killing, and suggests that when done in war, it may be justified as the right thing to do under the circumstances. Elsewhere, killing may be wrong – accidental or reckless – and individuals may offer excuses accordingly: they did not realize that the traffic junction was ahead or they lost control of the car because of exhaustion. Austin (1961: 125) reminds us that few excuses get us out of blame completely and the average excuse in a poor situation gets us only out of the fire into the frying pan.

In essence, if I am accused of doing something wrong, I may answer by giving a justification for my behaviour. I am attempting to persuade my accuser that my action was right in the specific circumstances. Alternatively, I may admit that the action was wrong and offer an excuse. I was clumsy because of an illness, I did not know the true facts of the situation, or it was an accident, which was never intended. By making these excuses, I hope to convince my accuser that I was not fully responsible for my actions and any associated blame should be modified accordingly.

Perhaps one of the most common “excuses” presented by people to explain their unhealthy lifestyle is addiction. People claim that they are physically addicted to nicotine, alcohol and even chocolate. Compulsive behaviour - those actions, which are driven by compelling physical or psychological need - are not voluntary in character. The individual is driven to act by an internal force beyond his or her control and the action should therefore be classified as involuntary. We should not blame individuals for involuntary actions and it follows that individuals are not required to justify such actions and they do not need to offer further excuses to defend their behaviour.

However, the initial choice to smoke, or take recreational drugs, may be voluntary and people are warned of the dangers of addiction, so they may be held partly responsible

for this behaviour. In addition, some people are successful in breaking habits of a lifetime, and they do give up smoking and/or alcohol. While people may 'say' they are addicted, it appears that the individual does have some control over whether they continue to indulge in smoking or drinking. It may be difficult for the individual to give up the unhealthy behaviour, but it seems that there is a voluntary element to this behaviour. Addicts can seek help from rehabilitation services, treatment from medical professionals, or support from psychological counsellors, in order to attempt to change their behaviour. Yet, perhaps those who do manage to give up unhealthy habits have 'stronger' characters and more will power (better genes) than others who cannot resist temptation. How do we know that those who fail can really help themselves?

Glover suggests that self-control is evident when the individual is able to alter his or her behaviour following information or changed circumstances. The alcoholic or drug addict, or indeed the kleptomaniac, is unable to make choices about their behaviour in specified areas and cannot help what they do. Glover (1970: 66) writes 'Sometimes a person's intention is one that he does not identify with, or endorse, and is one, that he would prefer to be without. A drug addict's intention to pursue his addiction may often be of this kind. Then it appears he is not capable of altering his intention, and this lack of capacity may well exempt him from blame.'

There is, however, no sharp distinction between the status of being and not being open to persuasion and it is difficult to say that a person is responding to a compulsive drive, which is irresistible. While some people can control their addictions, for a limited time, others appear to be unable to help themselves. Glover (1970: 99) writes 'A man is not one day merely a heavy drinker and the next day an alcoholic.' The nature of addiction may be a matter of degree and may therefore be accepted as excusing an individual from responsibility, partly or fully. This conclusion avoids having to adopt the idea that the addict is fully accountable or that he or she has no control over the addiction.

I do not want to suggest that because addiction may excuse some behaviour relating to tobacco, drugs and alcohol that it also releases one from responsibility in other areas of behaviour. Alcoholics, who choose to drive having consumed excessive alcohol, will still be legally and morally responsible for their actions. In the case of alcohol dependence, or indeed any other addiction⁵, we may be forgiving and supportive in some situations but not where the behaviour seriously endangers others.

⁵ Drug addicts who steal to fund their cravings will be held legally responsible for their actions

4.6 Should we blame people for their unhealthy lifestyle?

Even in cases where there are indications that people have contributed by their actions, to the development of their illness or injury, it does not follow that people should be blamed for the harm that has resulted. A distinction should be made between causal responsibility and liability responsibility. In the former one merely tries to establish a causal connection, but in liability responsibility there is an attempt to determine who is to be praised or blamed, rewarded or punished. We may even feel that the individual should be blamed in principle, since no relevant justification or excuse can defend the behaviour, and yet think that it would be wrong to blame in practice. The individual who becomes ill following reckless behaviour may already have suffered in excess of any blame that we might feel was appropriate.

The following scenario illustrates the distinction between causal responsibility and liability responsibility: someone may have caused an accident - the vase is smashed on the floor - but we do not attribute blame or punishment if the individual was unable to control their actions. Consider the person who has an epileptic fit, falls onto the table and causes the vase to crash to the floor. We might say that he or she was causally responsible for the broken vase but we are unlikely to apportion blame. (We might feel differently if he or she was a known epileptic who had deliberately chosen not to take the prescribed medication). The case of the epileptic person should be contrasted to the scenario of an adult who deliberately picks up the vase and throws it at an irritating dog. We would consider this adult was responsible and liable for his or her actions and if no excuses were offered, would probably judge this behaviour to be blameworthy and cruel. Our precise response will depend upon the context of the situation and it may result in sanctions, penalties and / or demands for compensation.

In this section, I wish to examine whether we should hold people accountable for their unhealthy behaviour. Do prudent people deserve⁶ access to health care and treatment in preference to others, who have taken known risks? Should we give priority and immediate treatment to those individuals who have adopted a healthy lifestyle, because of the 'Restoration Argument'? Finally, do the risk takers deserve *any* punishment? If this question is answered in the affirmative, then what sort of punishment would be appropriate?

Deserving is associated with doing.⁷ When we say that a person deserves his or her success, we are saying that it was not due to luck or favour that things went well, but rather that it was the result of his or her own efforts or characteristics. What people deserve depends upon what they have done in the past. We can say a person deserves promotion and success (it would be fitting for him to have this reward) but this is not the same thing as saying he can claim promotion as a right. Similarly, the defeated Member of Parliament may have deserved to win, because he worked excessively hard for his constituency, but he is not entitled to the position, unless he gains the most votes. Hence, Feinberg (1970: 86) states that "deserve," "fitting," and "appropriate" are contrasted with the terms "right," "entitlement," and "rule, and are used in different contexts.

Desert claims do not as such establish obligations on others (Sher 1987). If we say the keep fit enthusiast deserves to be healthy, or that the hard working student deserves to get high grades, we do not mean that anyone is obliged to take steps to provide what is deserved. Similarly, there is no legal obligation to punish people, even when it appears that they have deserved punishment, unless there are established local rules or laws.

Do some people deserve to be given lower priority in the allocation of health care resources because of their unhealthy lifestyle? In the current NHS, where resources

⁶ Pojman L.P. McLeod O. (1999) This collection of readings, focusing on the concept of desert.

are limited, decisions have to be made about who gets priority and access to immediate care. Those who do not get priority for treatment and have to wait are not being *punished*. Rather it may be an unfortunate consequence of the limited resources available. Doctors have to make difficult decisions about which patients are treated with the available resources, while delaying, or denying, other patients.

That those denied treatments are not being punished can be illustrated by an analogy. Consider the employer who has several staff but only one senior position to offer for promotion. The employer has to choose one of the staff for this post and he/she will probably choose whoever he/she thinks is the most highly qualified person for the post. The intention is to choose the best candidate for the job, and not to punish those members of staff who are not promoted. Consider the university, which requires certain examination grades as a condition for admission. There is no intention to punish those candidates, who do not successfully achieve the grades and are subsequently rejected.

As Feinberg (1970: 67) suggests the point of competition is to single out a winner, not to penalise the losers. Certainly failure to win a prize may be unpleasant and unwelcome, but the intention of awarding prizes is not to cause suffering for the losers. In contrast, an essential and intended element of punishment is that the victim be made to suffer for their former wrongdoing.

It is evident that we often do things to others which they do not welcome, and may even cause them harm or deprive them of enjoyment. In many situations there is no previous wrongdoing and there is no reason, or intention, to punish. Giving unpleasant medicine, or an injection, to the protesting child is not a punishment, and is not associated with any previous wrongdoing. If the child perceives that the medicine is a punishment one would make strenuous effort to reassure him/her otherwise.

In situations of scarcity, a delay or withdrawal of treatment, may reflect a decision to give priority to those individuals who have been prudent and consequently have the

⁷ Feinberg *Doing and Deserving* 1970

best clinical prognosis. Decisions about which patient should be treated, when only one can be treated, should not be based on desert. Rather these decisions should be based on a number of other criteria, including medical need, clinical and cost effectiveness and patient desire.⁸ It is well established that the outcomes of surgery and intensive therapy are more favourable for those individuals who are non-smokers, within normal weight range and are physically fit. While current health status may be an indication of who should be given priority, there is no need to enter into the problematic assessment of previous lifestyle and behaviour.⁹

However, individuals who voluntarily adopt an unhealthy lifestyle and take known risks with their health are not only harming themselves, but also harming others, who may have to pay more to meet the increased health care costs. In addition, the alcoholic who needs a liver transplant may use scarce organs, which will no longer be available for those who have developed liver failure through disease unrelated to lifestyle.

The 'Restoration Argument,'¹⁰ suggests that smokers and heavy drinkers should have their entitlement to health service resources reduced because they are less deserving than those who become ill through no fault of their own. In essence, the argument states 'Smokers need more health-resources than non-smokers. Given limited budgets, we must choose between treating everyone equally (according to need) or reducing smokers' entitlements. If we choose the former, non-smokers will be harmed by others' smoking, because there will be less resources available for them than if no one smoked' (Wilkinson 1999: 255). So the quantity of health care resources for non-smokers should be restored to that level which it would have been if smokers had not generated extra demand.

Writers including Smart (1994) and Glannon (1998) support the restoration argument. It is not about punishing smokers or heavy drinkers for their former behaviour and it

⁸ I have discussed these criteria in Chapter 2

⁹ The problems of assessing previous lifestyle will be examined in chapter 6

¹⁰ The restoration argument has been described by Wilkinson 1999, Smart 1994 and Glannon 1998

focuses on preventing harm to third parties so that there can be no accusations of paternalism, where the intention is to protect the individual from his or her own decisions. However, I am concerned with the first premise – that smokers use more health resources than non-smokers. There is recent empirical evidence¹¹ to suggest that this is not the case: smokers die at a younger age and hence do not need health care resources throughout their old age. Berendregt, Bonneux, and van der Maas (1997) conclude that if people stopped smoking, the long term costs of health care would rise. In addition, smokers and heavy drinkers pay taxes, which contributes a considerable sum of money towards the treatment of the anticipated health problems.

While Wilkinson (1999: 255) acknowledges that the restoration argument could be applied to any group of risk takers, it appears that smokers and heavy drinkers are frequently cited. It is apparent that value judgements are being made about the worth of only some risky lifestyles, as certain behaviour is selected while other risky behaviour is ignored. Should non-virgins¹² or parents¹³ pay for their anticipated increased health care costs? Indeed Wilkinson suggests that you might run the restoration argument in reverse and suggest that non-smokers should compensate smokers by having their entitlements reduced. Any policy based on this argument may therefore raise pragmatic difficulties and result in practices, which are intuitively unacceptable.

Proponents of the restoration argument, suggest that it is not about judging the merits of certain lifestyles, or punishing those who adopt unhealthy behaviour. Nevertheless, in practice a punitive approach is sometimes expressed towards those people who do not adopt a healthy lifestyle and conform to the expectations of the health care professionals. Anecdotal accounts suggest that staff do sometimes blame those patients who do not behave appropriately, as judged by the professionals. For example, those patients who smoke, or who repeatedly injure themselves by taking overdoses, or fail to comply with prescribed medical treatment or diet, are sometimes

¹¹ Barendregt, Bonneux, van der Maas The health care costs of smoking, *The New England Journal of Medicine* 1997, 337 (15) 1052-1057

¹² McLachlan Smokers, virgins, equity and health care costs *Journal of Medical Ethics* 1995: 210

¹³ Wilkinson Smokers' Rights to Health Care *Journal of Applied Philosophy* 16,3, 255

criticized in casualty departments or surgeries, and made to feel uncomfortable about their behaviour.

Such expressions of blame and scolding may be seen as a kind of informal punishment, (Mackie 1977: 209) and may be used as an attempt to modify a patient's behaviour. In addition, there are reported cases where patients are denied treatment, or given low priority on waiting lists, as a result of their smoking or other unhealthy behaviour, (Hall 1993: 4; Rogers L. 1993:1). While doctors might suggest that decisions about treatment are based upon clinical need and predicted outcomes, and managers might talk about setting priorities, it is possible that patients might feel that they are being punished for their former lifestyle. I will therefore examine the notion of punishment in relation to unhealthy behaviour in order to determine if it would ever be an appropriate response for those who have adopted an unhealthy lifestyle.

If I am responsible for what I do, it follows that I may be praised and sometimes rewarded for my good actions, and conversely if my actions are bad, I may be blamed, reprimanded and sometimes punished. Punishment involves the deliberate infliction of something inherently unwelcome; it may be either painful or a deprivation of some good. Since punishment is, by definition, meant to be unwelcome to the rational agent, it is necessary to justify why it is imposed. In most situations punitive action is associated with an explanation: I am sending you to your room because you did such and such; you are found guilty of and accordingly sentenced to three months imprisonment. Punishment is imposed on account of some wrong that the individual has allegedly done, and the association should be communicated and is, one hopes, understood. In this way punishment is a message, primarily addressed to the person who did wrong, but also and importantly overheard by others, who may also learn that this wrong doing is unacceptable to the present community, be that the family or society as a whole.

The justification for punishment has traditionally been considered mainly in terms of choosing between the claims of retributivists and utilitarians (Glover 1970: 142). In essence, the retributivist claims that the wrong doer deserves to be punished unless

there are relevant excuses or justifications to explain the behaviour. Accordingly, wrongdoers should be 'paid back' for their wicked deeds (Rachels 1997:470), and it follows that there should be some sort of equivalence between the offending act and the subsequent punishment. It is not only that punishing those people who commit crimes such as murder and rape allays certain vengeful feelings towards wrongdoers, but it is also a violation of justice if they are allowed to walk away freely as if they had done nothing wrong. Since a wrong has been done, appropriate suffering for the offender should follow it, which is reflected in the notion of an eye for an eye and a tooth for a tooth. We might, however, feel uncomfortable with this idea of retribution and suggest that it may result in unnecessary suffering for no apparent good.

The retributivist view is essentially backward looking and is therefore sometimes contrasted with the utilitarian approach which suggests that punishment is justified if it results in preventing or reforming the wrongdoer, and / or deterring other individuals, from indulging in the same wrong doing, in the future. The focus is rehabilitation for the offender and deterrence for others, who are informed of the punishment. For example, the prospect of losing a driving license has deterred many drinkers from over indulgence of alcohol. The utilitarian might suggest that withholding medical treatment from the individual who has adopted an unhealthy lifestyle is justified, because it will encourage the individual, and others, to avoid known hazards and adopt a healthy lifestyle. However, there is little empirical evidence to support this assertion, and it seems unlikely that the withdrawal of medical treatment will act as a deterrent, if the prospect of developing disease has not already persuaded individuals to modify their behaviour. In addition, withholding or delaying medical treatment, with its associated suffering, may cause undue misery, which outweighs the potential good of changing people's health related behaviour.

Honderich (1969: 31) proposes that a man's punishment might be justified if and only if '(1) he has behaved culpably, (2) his penalty will give satisfactions equivalent to the grievance he has caused, (3) it will be similar to those imposed on other offenders who have caused similar grievances, (4) he was responsible for his action and knew of the possible consequences under a system of offences and penalties, and (5) unlike non-

offenders he has gained satisfactions attendant on the commission of an offence.' I wish to examine whether these justifications would constitute adequate grounds to punish individuals by withdrawing medical treatment, because of their previous unhealthy behaviour.

In relation to the first justification: has the individual who adopts an unhealthy lifestyle behaved culpably? In the majority of cases it will be impossible, or exceedingly difficult, to determine whether individuals are liability- responsible for their health related behaviour. In many cases individuals may be able to present reasons to excuse their actions, and we may feel uncertain about whether the individual could have acted otherwise. The assessment of responsibility presents difficulties in practice, particularly in relation to lifestyle and health related behaviour.¹⁴ For example: are individuals responsible, or partly responsible, for their diet or will their family upbringing, culture and socio-economic circumstances largely determine what they eat and drink? Nicotine is known to be addictive, does this excuse the young man who started smoking in his early teens, before he fully understood the consequences of his behaviour?

The idea that withdrawal of medical treatment will give satisfaction equivalent to the grievances caused does not make sense, because individuals have invariably harmed themselves, by adopting an unhealthy lifestyle. It is not clear who will be given satisfaction, by the withdrawal of medical treatment from those patients, who are judged to have contributed to their illness.

The third requirement for punishment to be justified, proposed by Honderich, presents the idea of parity of punishment between offenders who commit similar crimes. In the case of withdrawing medical treatment from individuals, there can be no guarantee that the outcomes will be similar. Some patients may die while waiting for treatment, as in the unfortunate case of Harry Ephick (Iliffe 1993: 5), while others may experience no more than mild anxiety and slight inconvenience because of the delay. Underlying

¹⁴ Further discussion about the difficulties of assessing whether a patient is responsible for his/her health status will be developed in chapter 6

pathology, and genetic predisposition, will largely determine the effect of delaying or withdrawing treatment and it may not equate to previous lifestyle. There are many heavy smokers, who suffer no adverse symptoms, and would not be punished in any way, by a policy, which suggested treatment should be withheld, or delayed, from smokers.

In relation to the fourth justification for punishment, as proposed by Honderich, we should ask if individuals who smoke, overeat, or drink excessive alcohol know that they may forfeit future access to health care? It is not clear that they have broken any rules, and successive governments have repeatedly reassured the public that health care on the NHS will be available to all, according to clinical need. Neither '*The NHS Act*' (1979) or '*The Patients Charter*' (1991) or '*The New NHS: Modern. Dependable*' (1998) suggests that those people who adopt unhealthy behaviour will be treated differently from any other patients. If the intention is to punish people for their unhealthy behaviour, it would seem necessary and desirable to provide clear guidelines, and explicit criteria, about which behaviour will be punished, so that people can make decisions about how to behave, with this knowledge.

The final justification for punishment, in this list, suggests that offenders have gained satisfactions from their offence which non-offenders have not experienced. While it is possible, and even probable, that people who adopt unhealthy behaviour have enjoyed a good time, there is no guarantee here, and they may now be suffering from the illness and disease, which may have partly resulted from their overindulgence. It is not justifiable to add further suffering by delaying or withholding medical treatment.

In essence, patients who are ill should not be punished for their former lifestyle: it is difficult to justify punishment generally and there are real concerns about withdrawing or delaying treatment from those with medical needs. Such action would be unduly harsh and contrary to the values of medicine. Glover (1970: 153) makes an important point when he states that 'punishment is only justified if there are good grounds for thinking that, as a method of achieving the aims in question, punishment causes less harm than any other equally effective method.' There can be little doubt that

withholding or delaying medical treatment will result in anxiety and potential suffering, both for the patient himself, and perhaps for relatives and friends.

If we say individuals deserve *particular* penalties or punishments, it suggests that they have behaved culpably *and* that there should be some relationship between their culpability and the distress of the proposed punishment. There should be some 'equivalence' (Honderich 1969: 15 -23) between the wrongdoing and the proposed punishment. Contemporary society usually apportions greater blame for a violent assault, than for a minor theft such as shop lifting, which is reflected in the penalties imposed by the judiciary for such actions. Yet, when considering culpability we do not only consider the resultant harm of the action, since we are also concerned to determine if the individual was responsible for his actions. Greater culpability is attached to intentional and planned acts of violence, as contrasted with accidental injury, such as that caused by careless driving. Hence Honderich (1969: 16) writes 'The culpability of an offender in his offence depends on two things: the harm caused by his action and the extent to which he can be regarded as having acted responsibly'

Indeed, we should question whether it is ever possible to fix a penalty or punishment whose distress has some equivalence of that caused by the offence. Distress is clearly subjective and it is difficult, if not impossible, to determine accurately how much harm is caused to any individual. For example, consider the man whose car is stolen: to what degree is he harmed? He may, after all, be able to travel on the bus, and replace the car with his insurance, but he may feel that the loss of his car amounts to more than the loss of the ability to get from A to B.

It is not at all obvious that the person who has led an unhealthy life, and has been unfortunate enough to succumb to disease, deserves to forfeit future health care. Rather, we might consider this a severe penalty, out of proportion to any supposed misdemeanor that has taken place. The individual has not deliberately hurt someone else; rather he may have been imprudent, unwise, or weak willed as he succumbed to temptation, often planned and orchestrated by a marketing department. The effects of advertisements for alcohol, cigarettes and chocolate should not be underestimated. In

addition, individuals may have been ignorant of the facts, or have denied the reality of the inherent risks of their behaviour. In many cases, we may feel that these individuals are naive, but there is no reason to suggest that they deserve punishment. Indeed the individual who develops lung cancer following years of smoking may feel he or she has already met with sufficient suffering.

We should therefore feel uncomfortable about suggestions that individuals 'deserve' to forfeit health care, because of their former unhealthy behaviour. There are difficulties, both in terms of determining whether individuals are responsible for their actions, and in respect of the so-called punishment being equivalent to the 'offence' committed. Indeed, the idea of punishing anybody who is ill and suffering from a disease, which requires medical treatment is repugnant. The justification for punishment presupposes that an individual has done wrong, and has deliberately broken an established and known rule. Those individuals who smoke in the privacy of their own homes have not broken a rule as such, even if they have ignored health warnings. They may have been unwise or weak willed but they have not done wrong. Similarly, the individual who fails to eat five pieces of fruit or vegetables a day has not broken a rule which he / she is obliged to follow, although it would be sensible behaviour.

There are alternative approaches, than the use of punishment, to discourage unhealthy behaviour. These include health education and promotion, which are not associated with the distressing effects of punishment. In addition, the total prohibition of cigarette production would arguably be a more effective method of reducing nicotine related illness, than any system which penalized smokers for their previous behaviour. These strategies¹⁵ are preferable to any form of punishment or punitive behaviour for those people who take risks with their health.

¹⁵ These strategies will be explored in the next chapter.

Chapter Five

HEALTH PROMOTION – THE ACCEPTABLE LIMITS

- 5.1 The value of health
- 5.2 Health promotion and health education
- 5.3 Persuasion and Manipulation
- 5.4 Coercion
- 5.5 Legal Prohibition
- 5.6 Is paternalism justified in health care?

5.1 The value of health

We can assume that individuals would normally choose to be healthy in preference to being ill or unwell - health is an asset, which is welcomed even if people do not always recognize it, until their health is impaired or threatened. The British government has unequivocally stated its commitment 'to the pursuit of health in its widest sense' (Department of Health 1992: 2), but does not clarify exactly what it means by this assertion. Indeed, health is notoriously difficult to define and a variety of different definitions are presented in the literature.¹ I do not intend to explain the merits of these contending definitions, since I am only concerned to make the point that health (however defined) is a valuable goal for individuals and the community as a whole.

Aristotle states that there are some things in life, which we actually ought to desire and cites health and learning as examples (Aristotle 1976: 115). In addition, Plato argues that some goods 'are worth choosing not only for their consequences but also, and far more, for themselves, such things as sight, hearing, intelligence, health, and all other qualities which bring us a real and not merely an apparent benefit' (Plato 1974: 114). Health is a value in itself and also an instrumental value, which allows individuals to lead a full and good life. This idea is implicit in Seedhouse's description of health as 'the foundation for achievement' (Seedhouse 1986). While ill health and disability do not prevent an individual from achieving great goals, good health will usually make it easier for individuals to achieve their various desires.

Health is a benefit for the individual and it is also a benefit for the community. It is stating the obvious to say that disease and premature death can cause distress for both the individual afflicted and those who are closely involved. Relationships with family,

¹ For a helpful discussion on "What is Health?" See Dines A. Cribb A. Health Promotion Concepts and Practice Blackwell Scientific Publications 1993 Chapter 1 pages 3-19

friends and colleagues are important and people value the bonds and commitments, which are formed in society. Ill health and the premature death of a 'significant' person affects future plans and ambitions, and may cause great sadness for others.

If the population remains healthy the costs of health care may be reduced, waiting lists may be shortened, and there might be a more prompt service for those who need care. The benefits to a community whose members are healthy are far reaching; fewer days off sick, increased productivity, economic growth and the associated general benefits. There might even be more available money for health promotion and health care.

Improved health for the community has the potential to reduce the financial costs of the hospital and acute services. There has been a shift in emphasis from a health service which focused on curing the patients, towards a more holistic service which includes health promotion and prevention of disease (Department of Health 1992). This could be motivated more by concerns to reduce spending on the NHS, rather than concern for the interests of the individual. The government is currently responsible for the provision of health care in the NHS and there is an obvious financial incentive to encourage individuals to adopt a healthy lifestyle, which reduces the risk of certain diseases and their associated costs.

This cost-containment argument should be viewed with caution since it cannot be assumed that health promotion will reduce the overall costs of health and social care. If people adopt a healthy lifestyle they may live longer and so create greater demands on the NHS or any alternate provider of health and social care.

Nevertheless, I conclude that health is valuable for both individuals and the wider community, but other things in life are also valuable and health is not always preferred. We all take part in activities, which may potentially put our health at risk either in the

short or long term. Those people who participate in dangerous sports are usually well aware of the immediate risks to life and limb, and there is wide publicity about the long-term consequences of overeating and smoking, yet people continue to indulge themselves. So it appears that health is not an overriding goal at all times.² Indeed, Blaxter (1990: 214) has presented empirical evidence to suggest that ‘substantial proportions of the population did not see health as the most important thing in life.’ For some people it may be equally or more important to take part in their chosen activities, sports or adventures, so that life is pleasant and / or exciting.

While health care professionals may consider it important for the patient to give up smoking or alcohol, the patient may feel that the habit is one of the few pleasures in life, which outweighs any harmful risks to future health. Ironically giving up smoking could lead to increased stress, family rows and depression for the individual, who might feel correspondingly less healthy. Compliance with medical advice might reduce the probability of future disease but may ‘cost’ the patient in terms of increased physical and mental side effects. This is well illustrated by the frequent non-compliance in the use of antihypertensive drugs. Many patients find the side effects distressing and choose not to take the drugs as prescribed, despite knowing that there is an increased risk of stroke or cardiac problems. It is not irrational for people to be willing to risk a shorter life, in order to have a happier life.

I have suggested that health is valuable for both individuals and the wider community, and it is therefore reasonable if individuals and the community seek to promote health. Education, which enables individuals to make informed decisions and adopt behaviour, which promotes health, is morally praiseworthy. If given information about the risks of certain activities some individuals will change their behaviour but it is also clear that many others will not change their lifestyle or habits. But is it justified to adopt more

² Occasionally people may desire and claim ill health. Consider the person who wishes to avoid work or school, or gain sympathy. Such a desire is generally short-lived.

strident measures in order to manipulate, coerce, or even force people by legislation, to adopt behaviour, which will promote their health?

While education which respects individual choice is widely accepted, there may be more reservations about the adoption of any measures or strategies which limit the freedom of the individuals to choose their own health related behaviour. In this chapter, I will clarify some of the different approaches, which might be employed to promote the health of individuals. These strategies include health education, persuasion and manipulation, coercion, and legal prohibition. Such approaches are evident in practice, and I will therefore examine them in turn, in order to determine whether or not they would benefit the individual and / or the community as a whole.

Finally, since I have proposed that health is an important and valuable asset for individuals themselves, the question arises as to whether paternalism is justified in health care? Should the government impose paternalistic restrictions in order to protect individuals from their own choices, lack of control, ignorance or foolishness?

5.2 Health promotion and health education

Health promotion is a diverse, complex and multifaceted activity, which is difficult to define. It appears to be an umbrella term, which has been used to cover the overlapping fields of health education, prevention and attempts to protect the public health through social engineering (Tannahill 1984: 196). Health promotion therefore includes a variety of activities. These include lobbying to bring about healthy public policy at government and local levels; campaigns to end tobacco advertising; the introduction of higher taxation on cigarettes; the construction of cycle paths and the fluoridation of the water supply. This broad approach to health promotion is compatible with the ideas of Lawrence Green (1987: 4) who defines health promotion as 'any combination of health education and related organisational, economic and environmental supports for behaviour conducive to health.'

The Ottawa Charter for Health Promotion (World Health Organisation 1986) identified five 'action strategies' for health promotion:

Building healthy public policy

Creating physical and social environments supportive of individual change

Strengthening community action

Developing personal skills such as an increased self-efficacy and feelings of empowerment

Reorienting health services to the population and partnership with patients.

These strategies reflect several ethical concerns including voluntariness, participation and empowerment of individuals and the community. A deliberate move away from individual responsibility and victim blaming is evident.

Health education has been defined in various different ways reflecting various underlying philosophical positions. Downie, Fyfe and Tannahill (1990: 28) adopt the

following definition: 'Communication activity aimed at enhancing positive health and preventing or diminishing ill-health in individuals and groups, through influencing the beliefs, attitudes and behaviour of those with power and of the community at large.'

This is a broad approach, which reflects the importance of 'enhancing positive health' rather than merely focusing upon disease prevention.

By definition, health education implies that individuals should choose to adopt health-promoting behaviour. Various models of health education are described in the literature. The preventive medical model aims to prevent disease by giving people information about the risks of certain behaviour and persuading them to adopt a so-called healthy lifestyle (as determined by the health care professionals). The focus is primarily on individuals who should take responsibility for their own health-related behaviour.

Health education can be viewed as a process of 'critical consciousness raising' (Tones and Tilford 1994: 20) which aims to give people a deeper understanding of their circumstances and their capacity to influence those circumstances. The emphasis is less on persuasion and more on support and the goal is not one of manipulation and compliance but, rather, empowerment and facilitation of choice (Tones 1997). Any education strategy, which gives the individual an increased understanding of health and illness, and enables people to take positive action to maintain health, should benefit the individual and the community as a whole. Since the choices of the individual are respected there can be few criticisms of such an approach.

Interest in health education has been rising because there is increasing evidence that many of the most serious problems of health are associated with specific behaviour and lifestyles. Government statistics reveal that 'Every day in England heart disease and stroke kill nearly 550 people; every day 370 die from cancer; every day 26 perish in

accidents, many of them on our roads' (Bottomly 1993: II). Many of these deaths are premature and could be prevented if individuals changed their behaviour, especially if they stopped smoking, altered their diet or gave up driving the car.

The increasing importance of health education is not therefore surprising, since there is great potential for individuals to change their unhealthy behaviour, and avoid known risks. There is empirical evidence to show the benefits of changing behaviour and in particular the benefits of giving up smoking. Those who give up smoking for ten years have a risk of lung cancer that is half that of a smoker, and the risk of heart attack falls to the same as someone who never smoked (Royal College of Nursing 1997: 6).

It is obviously important that people should have information so that they can make decisions about their behaviour. People should be aware of the risks, which are associated with certain activities such as smoking, rugby and excessive alcohol, so that they can decide whether they wish to partake. There are however, two important issues to recognize when reviewing health education. Firstly, health education will not necessarily result in people changing their behaviour. If people are allowed to choose how to behave, they may continue to take severe risks, drive cars without seat belts, continue to smoke, and eat unhealthy things and their health will sometimes suffer. Indeed, significant numbers of the young actually take up smoking knowing that there are serious risks to their health. Every day in Britain, an estimated 450 children start smoking (Royal College of Physicians 1992) despite high profile campaigns to illustrate the inherent problems of smoking.

Are the government or local policy makers justified in adopting coercive strategies in order to make people change their behaviour? I have argued that health is a value in itself and an important factor in achieving the goals of life generally, and it may therefore be morally justifiable to adopt a more persuasive and forceful strategy to

promote the health of both individuals and the community as a whole. There is a convincing argument that health education in schools about smoking and drugs should aim not just to *inform* but to *change* future behaviour. The intention is to prevent children, for their own benefit, from starting these potentially addictive habits. In addition, these strategies may need to be forceful if they are to counter balance and free individuals from the powerful affects of the family environment, peer pressure, and the influence of advertising campaigns.

There is a second issue to recognize when evaluating health education. Strategies to promote health should not focus exclusively on the education of individuals. Lifestyle is only one of a variety of factors, which determine health. Calman (1990) suggests that there are at least five factors which interact to influence the health of an individual or population including biological factors, the environment, social and economic factors, use of and access to health services, and lifestyle. Known sources of illness, such as poor working conditions, poor housing, pollution, and local amenities for sport should be examined and improved if necessary. There is an irony in encouraging people to take more exercise, and bike to work, if the air that they breath is polluted to the extent that it will contribute to ill health.

Health education, which emphasizes individual responsibility for health, should not detract attention from the wider environment, which clearly affects the decisions which people are able to make about their health related behaviour. Strategies which focus exclusively on individuals ignore the most consistent of all findings about the causes of ill health: the 'clear gradient of declining health with declining socio-economic status' (Campbell 1993: 21), which remains in Britain despite the NHS (Whitehead 1987). If we are genuinely interested in promoting health we need to create a climate where individuals are enabled to make healthy decisions for themselves, if they wish.

The following scenario illustrates this argument: members of a local community wish to reduce the number of accidents and harm to children biking to school. It is inappropriate to focus exclusively on developing children's cycling skills and knowledge of the Highway Code with no corresponding attention to road safety generally. The most effective way of reducing cycling accidents might be to implement a network of cycle paths and reduce the speed of road traffic where there is no alternative route. A multifaceted approach may be desirable to reduce the rate of accidents. In addition, it might be relevant to consider the contentious issue of whether legislation should be introduced in order to make the wearing of cycle helmets compulsory for children when riding bikes on the road.

Government policy recognises that there has to be a balance between what individuals and their families can do, and what the government and other organisations can do (Department of Health 1992). The White Paper, '*The Health of the Nation: A Strategy for Health in England*' recognizes the importance of the local environment, and the socio-economic circumstances, which influence the health status of individuals, but there is still an emphasis on people changing their lifestyle. The potential problem of victim blaming therefore still remains an issue.

In conclusion, the practice of health education is widely accepted as a strategy to promote health on the assumption that the choices of the individual are respected. However, education is not always effective as a means to improving health: people will continue to adopt lifestyles, which will potentially harm their health. In addition, education may focus exclusively on the individual, which can detract attention from the wider issues of promoting an environment where people are able to make healthy decisions.

5.3 Persuasion and Manipulation

‘Health promotion is about individuals receiving information, assessing their personal risk and then making choices’ (Blinkhorn 1995: 24). If this approach is accepted, it follows that health promotion should not be about the wholesale conversion of the general public and it should not threaten or cajole people to change their behaviour. This view of health promotion is evident in various theoretical accounts (Tones 1987: 41-52; Downie, Fyfe and Tannahill 1990), but in practice doctors, nurses and midwives may adopt persuasive or manipulate strategies in order to make their patients adopt healthy behaviour. In this section, I will examine whether such persuasive or manipulative strategies can be justified.

It is difficult to draw firm boundaries between enthusiastic education, aggressive marketing, persuasion and manipulation: all these activities attempt to influence the perceptions of individuals so that they agree to pursue a specific set of activities or goals. A variety of methods can be adopted in practice, information can be presented in a biased fashion, certain facts can be withheld or exaggerated, tempting rewards may be offered or withheld. There are degrees of persuasion ranging from friendly encouragement to more forceful strategies, which might even include the tactics of the bully. There are also different forms of manipulation, which may involve deliberately withholding specific information or deception. Deliberately deceiving patients is rarely justifiable because of the potential harm to future communication and trust.

Individuals may be persuaded or manipulated for their own good, which may excuse or justify the process. Persuasion and manipulation may aim to change people’s own preferences. Since persuasion and manipulation may occur in a variety of ways and in various circumstances, it is helpful to examine a particular case in the health care context.

In this section, I wish to examine the 'Baby Friendly Initiative' BFI, which was part of a global campaign launched by the World Health Organisation, WHO and the United Nations Children's Fund (UNICEF) in 1991. The objective was to promote 'infant and child health through the protection, promotion and support of breast feeding' (Murray 1996). The initiative focused on the care of mothers and babies in hospitals, after birth, since it was claimed that many of the barriers to breast feeding were established in this initial period. It appears there was an attempt to change the behaviour of women, which involved more than giving information in order to facilitate choice.

As a response to the Baby Friendly Initiative, it was reported that one Health Care Trust implemented a policy which informed community nurses that they should not discuss formula milk and 'should not provide instructions on how to make up feeds unless specifically requested to do so by the women' (Williams 1996: 14-15). The idea that nurses and midwives should not give women information about reasonable options such as bottle feeding, unless requested, appears to be an attempt to influence their decision and limit their choices. There were also unsubstantiated reports, which stated that mothers had to curtain off the bed if they chose to bottle feed (Williams 1996: 15) and were made to feel guilty.

Andrew Radford, Programme Director of the BFI, states that 'bottle feeding should not be presented as routine' (Radford 1996: 16). He suggests that teaching bottle feeding during antenatal classes reinforces its image as the normal way to feed a baby, and that such teaching should therefore be avoided. However, in reality the statistical evidence suggests that bottle feeding is one of the normal ways to feed babies. In the U.K. only sixty three percent of mothers breast feed initially and only forty percent will still be breast feeding six weeks after the birth (Jones 1996: 10).

Since the evidence suggests that the majority of women will give bottle feeds, there appears to be a responsibility for nurses and midwives to ensure that mothers are given accurate information about the safe preparation of these feeds. If mothers do not have the knowledge about sterilization and the correct methods of preparing formula feeds there is an increased risk of harm for the baby. There appears to be an underlying assumption that withholding information about bottle feeding will in some way deter mothers from adopting this method of feeding for their babies, and yet bottle feeding is widely accepted in society.

The most obvious justification for these policies is that breast feeding should be promoted since it can save more lives and prevent more morbidity than any other health strategy (Radford 1996: 16). Over the last two decades, there have been a number of research studies which show the benefits of breast feeding for the health of both mothers and babies (Lutter 1990). Few people would dispute the advantages of breast feeding in respect to future health of both the mother and baby. However, I have argued that health is one of a variety of priorities for each individual and not necessarily the supreme value. In certain situations, it is reasonable to give precedence to other values while recognizing there may be negative implications for health. A mother who is considering how to feed her baby does not make the decision in a social or cultural vacuum and a number of factors will affect her decision. For example; she may have to work to provide the family income, she may wish to involve her partner in feeding or she may be influenced by her family and the convenience of sharing the care of the baby. Whether she chooses to breast feed or bottle feed is her choice and it will depend on the situation, and not entirely upon future health.

Since the decision to breast feed or bottle feed does not solely affect the mother's own health, it is reasonable for health care professionals to emphasize the needs of the infant. However, it is evident that many babies in the U.K. who are bottle fed are

relatively healthy and even thriving. The potential risks of bottle feeding in this country, where effective sterilization can be maintained, should not be exaggerated. If the risk to health is minimal then mothers should be able to make their own decisions without pressure, manipulation or interference from health care professionals. In the U.K. there is probably a greater risk for the baby travelling in a car and nobody suggests that mothers should avoid taking their babies on car journeys.

In contrast, in developing countries if clean water is not available, and sterilization is difficult, the potential harm to the health of babies from bottle feeding may be significant. Persuasion or manipulation may in that case be justified in order to reduce the number of mothers who bottle feed their infants, in order to protect the health of babies and children. In 1981 the W.H.O. estimated that 1.5 million infants died each year because they were not breast fed (Rundall 1996). Such a figure is hard to ignore and may justify policies, which attempt to influence the choices of mothers.

There is a second argument to justify persuasive strategies and the withholding of information about bottle feeding: such tactics are necessary to redress the balance and combat many years of aggressive advertising by the manufacturers of formula feeds. For example, in 1990, Farleys, a British company, spent three million pounds promoting one product - Ostermilk (Palmer and Kemp 1996). In contrast, most health authorities relied on posters and encouragement from some committed midwives and health visitors to promote the benefits of breast feeding (Beeken and Waterston 1992: 286). I say 'some' midwives and health visitors because this study found that there was some ambivalence towards the benefits of breast feeding amongst these health care professionals.

Health promotion should aim to free individuals from the possibility of indoctrination by manufacturers, friends or family, or health care professionals. Patients in hospitals

are typically in unfamiliar surroundings, anxious and not feeling their best. The potential for salesmen, or others, to impose a set of values is enormous, and new mothers may not have the energy to resist. In recognition of the vulnerability of mothers to advertising campaigns, hospital practice has changed in recent years; representatives are no longer allowed to distribute free samples or promotion leaflets for formula feeds on several maternity units.

I would suggest that withholding information about bottle feeding and persuading mothers to breast feeding, during these early stages of development, is justified in order to overcome years of powerful advertising and social pressure, in both the developing countries and the United Kingdom. Since there are a variety of different methods of persuasion there is a need to be more precise. While it is acceptable to encourage mothers by enthusiastic marketing, emphasizing the advantages of breast feeding, it is unkind to bully mothers by ostracizing them and inducing feelings of guilt for those who decide to bottle feed. My point here is not that persuasion and manipulation are never permissible, but merely that only some forms of persuasion and manipulation in health care are justified.

I wish to make a further comment about the Baby Friendly Initiative. I have argued that it is inappropriate to focus exclusively on the behaviour of individuals when trying to promote health. It is also vital to consider the wider environment in which mothers will make their decisions about how to feed their babies. Yet this initiative merely presents 'ten steps to successful breast feeding' which focus on trying to encourage and support the mother in her initial attempts to breast feed. I suggest that the campaign should also consider the wider implications and long term problems of breast feeding in the community, which may also affect the mother's decision.

For example, in Norway there is a policy, which allows mothers extended maternity

leave, and breast feeding is encouraged in public places;³ breast feeding rates are in the region of 98.5% (Chaffer 1997: 73). In addition to focusing on the mother's behaviour, the U.K. Baby Friendly Initiative should attempt to change the general public's attitude to breast feeding, and lobby for extended paid maternity leave.

Finally, it is interesting to compare the Baby Friendly Initiative with the current attempts to promote the health of potential drug users. Campaigns to inform the young of the dangers of drugs have included slogans such as 'Just say No!' On the assumption that people should not inject recreational drugs, is it appropriate for health promoters to withhold any information about the use of needles and syringes? Such a strategy would appear to be naive since there is evidence that some young people will experiment with injecting drugs. Giving information about needles and syringes does not encourage the use of this equipment and indeed it could be presented in conjunction with relevant facts about potential risks and side effects of such behaviour. In this way individuals will gain more information on which to base their future decisions. Such information could prevent the spread of HIV and AIDS and so maintain the health of those individuals who choose to experiment and take risks.

Health education about the use of drugs must overcome the powerful effects of peer pressure and the popular idols. When Noel Gallagher of Oasis says drugs are 'as normal as having a cup of tea,' (Delingpole 1997: 17) this sends an influential message about the acceptability of drugs to his numerous fans. It is difficult for the so-called 'establishment' to counter balance this type of message without sounding out of touch with the younger generation. Persuasion, hard selling and manipulation may be justified to convince the young of the inherent harms of intravenous drugs, in order to prevent their use, and so promote the health of individuals. In this scenario, it is also relevant to note that many of these drugs are addictive and therefore it is justifiable to

³ In contrast, in the United Kingdom, women MPs were banned from feeding their babies in Commons committees (Sylvester 2000: 1)

try to persuade the young not to start experimenting.⁴

In summary, health care professionals do adopt some persuasive and manipulative strategies in order to promote the health of individuals. Such methods may deviate from the ideals of health education to respect the patients' choice and yet they may be effective strategies to improve the health of individuals and the community as a whole. Insurance companies also offer tempting incentives, such as reduced premiums, to persuade individuals to adopt a healthier lifestyle, to stop smoking or keep their weight within a normal range. Individuals may change their behaviour as a result of persuasive or manipulative interventions and might correspondingly improve their chances of future health. (There is of course no guarantee here!)

If mature adults choose to continue acting in ways, which are potentially harmful to their health, knowing and understanding the risks, then this is their choice. Health care professionals must recognize that individuals should have the freedom to choose other priorities besides health. Whether those individuals who choose to adopt an unhealthy lifestyle should be helped with the costs of treatment and care, for the illness which may result from their choices, is a different question, and one that should be discussed separately.

⁴ The prohibition of addictive drugs will be discussed in section 4 of this chapter.

5.4 Coercion.

Should the government, local authorities, or health care professionals adopt coercive strategies, in order to promote the health of both individuals and the community?

Hayek (1991) suggests that coercion occurs where individuals are made to do particular things by other people. In contrast, restraint occurs when people are prevented from doing things that they might wish to do. If you are locked in a room against your wishes, you are restrained and it would be inaccurate to suggest that you were coerced. These are alternative ways of interfering with people's exercise of their free will.

Nozick (1972) suggests that coercion can occur in various forms including threats, offers and warnings. I will examine each in turn, since all these strategies are evident in health care and health promotion. According to Nozick, coercion is associated with threats and with the suggestion that there will be unwelcome consequences, which the recipient would not willingly choose. The suggestion to heavy smokers that their future treatment and surgery may be delayed or withdrawn is a threat. Under normal circumstances and according to rights established in The Patients Charter (1992), health care is available according to clinical need on the NHS. The threat of delayed surgery may cause significant anxiety and the delayed treatment can potentially harm the individual and may even contribute to the loss of life. The doctor or administrator who threatens to withhold the provision of health care is depriving the patient of a service, which is normally offered, in order to coerce the patient into giving up smoking.

Most governments will refrain from imposing explicitly coercive threats upon their citizens in respect to health. The exception is where activities pose significant risk to the health of others, as in the case of drink driving, or the spread of infectious

diseases.⁵ However, theoretically, the government could intervene in a paternalistic fashion in order to coerce people to behave in a healthy way for their own benefit. Wikler (1978: 303) discusses the idea of a 'fat tax' which would require individuals to be weighed and taxed if overweight. If the government held these taxes in trust and agreed to return the money, if and only when, the individual lost an appropriate amount of weight, it would constitute a coercive strategy. While such a policy seems improbable, it might be an effective strategy in making individuals lose weight and it might improve their prospects of good health.

Many insurance companies offer private health schemes where the charges are higher for those individuals who are overweight or smoke. The premiums may be reduced if individuals change their behaviour, and can provide evidence of a healthier lifestyle. There is a coercive element to such policies, which may be threatening, but might alternatively be viewed as an offer, which induces and rewards those people who maintain a healthy lifestyle.

There are situations where it is unclear whether a person is making a threat or an offer because the normal and expected course of events is unclear. Nozick (1972) illustrates this blurring of boundaries with the example of a drowning man named Q, who may or may not be rescued by P, who is in the only nearby boat. In brief, P says to Q that he will only take the drowning man in the boat to the shore if he first promises faithfully to pay a considerable sum of money. Is P offering to rescue Q or is he threatening not to save Q?

In the light of this example, it is interesting to consider the provision of private health care. If there was no comparable or alternate NHS provision for health care, one

⁵ According to the Public Health (Control of Disease) Act 1984, a local authority can detain a person suffering from a notifiable disease, such as tuberculosis. For a person to be detained they must pose a serious risk of infection to others (Coker 1999: 1435).

could ask surgeons who demanded high fees for their services whether the intention was a threat to withhold services or an offer to care. I suspect that such a question has the potential to cause some unease, and in a climate where the NHS provision is being withdrawn, in areas such as cosmetic surgery, it may be a relevant question to discuss, but it is beyond the scope of this thesis.

In the majority of cases the distinction between a threat and an offer is clear. If the predicted consequences of the intervention are worse than those which could have been expected in the normal or natural course of events, the coercion is seen to be threatening. On the other hand, if the proposed consequences are better and the recipient welcomes the change then an offer has been made. Nozick suggests that normally people are not coerced into performing actions following offers, because they still retain the ability to choose from the available options. So offers of increased earnings, money and rewards are not normally perceived as threatening, since most people welcome them.⁶

Nevertheless, in some circumstances offers may appear to be coercive and there have been examples of offers where an individual has limited choice and has to comply or suffer unacceptable alternatives. For example, in the United States, women convicted of harming their children have been offered the use of long-term contraceptives such as Norplant, as a condition of probation. The alternative is a period of detention in prison, which does not present the woman with a feasible alternative choice (Dresser 1995: S15-S18).

In Britain there was concern about the morality of offering cash for human organs such

⁶ The Government's NHS review is considering the suggestion that mothers should be paid to breast feed their babies. The offer of £10 per week would be a financial incentive for mothers to breast feed, and would encourage mothers to choose the more healthy option of breast feeding, rather than bottle-feeding (Sylvester 2000: 1). This is clearly an offer, which promotes choice and would be welcomed by most mothers. It does not appear to be coercive or threatening.

as kidneys. If a person, who has no money or ability to raise funds, is offered a relatively large sum of money for his or her kidney the offer may appear coercive since the individual has limited freedom to say no. The offer is too good to refuse and the vulnerable individual cannot reasonably be expected to decline. However, Steinbock (1995) questions whether this type of generous offer is coercive since it appears to increase the choices available for the individual. She suggests that the offer may exploit the poor person and take unfair advantage of his or her situation. Assuming such offers are exploitative, we rightly object to the practice, but this objection is not based on the notion that the offer is coercive. One might, however, argue that this offer is both coercive and exploitative for those who have limited money.

The notion of warnings can be considered in relation to coercion. A teacher can warn students that they will fail their assignments if they do not work harder. The intention is to motivate the students to work harder and inform them of the likely consequences of their idleness. The warning does not appear coercive or threatening because the students can still choose whether to work harder or trust to luck. When giving this warning the teacher is informing the students of the probable outcomes of their actions but the announcement does not alter the consequences, or reduce their options.

If the teacher gives the students false information about their progress, the warnings are deceptive, and may be manipulative. Similarly, if a health care professional exaggerated the risks of certain behaviour this might be manipulative. It could nevertheless be an effective strategy for health promotion, until the deception is discovered. In the event of an individual becoming aware of any deception there may be a corresponding loss of trust and future communication may be difficult.

Warnings have been evident in health education in relation to a variety of lifestyles. The dramatic depiction of tomb stones in the television campaign to increase

awareness about the spread of the HIV virus warned of the possible consequences of unprotected sex. The advertisements attempted to make individuals change their behaviour by giving information about the consequences of such behaviour and perhaps instilling a sense of fear. The warning is not coercive if individuals can still make their choices with regard to how to behave, based on relevant and accurate information.

In summary, threats are coercive because they reduce one's choices and are normally unwelcome to the recipient. Offers are not coercive since they do not restrict choice. Warnings are coercive if they are deceptive and do not portray an accurate picture of future events. It is significant as to 'whose will is operating, whose choice it is, whether the act is fully voluntary, done willingly or unwillingly and so forth' (Nozick 1972: 132).

Is it ever justifiable for health care professionals to be coercive in order to promote health? It is important to note that coercion in itself is not always unjustified or improper. In some situations coercion is widely accepted as a valuable method of achieving important goals for the community. Even libertarian writers, such as Robert Nozick and Hayek, accept some forms of coercion are necessary. For example, limited taxation, compulsory education for the young and immunisation programmes are justified because of the benefits to the whole community, even though the freedom of the individual is thereby limited.

I suggest that some coercive measures are justified in health care and health promotion. Such strategies may be effective in making people improve their lifestyles, but the restriction on individual liberty should be recognized. There is also a need to be more specific about which forms of coercion are acceptable and which are not. I propose that threats within health promotion are not justified. For example, the threat

to withhold future health care is not justified because there is little evidence to suggest that this threat will be effective in making people improve their health related behaviour. If people have not changed their lifestyle because of the fear of illness or injury, it seems unlikely that the threat to withhold treatment will be effective. Indeed, it may increase fear and anxiety for those who are having difficulties in adopting a healthier lifestyle. I have argued that health is not the only value for people and that they should be able to make choices about their lifestyle and health related behaviour. The use of threats in health promotion is not therefore justified, since they reduce the possible choices for the individual.

On the other hand, offers of rewards and financial incentives, in health care and health promotion, are justified. Firstly, people will usually welcome such offers. Secondly, offers will increase the number of available choices for the individual. There can be no objection to making positive offers to encourage people to adopt and maintain a healthy lifestyle, if they genuinely increase choice for individuals. The recent suggestion that mothers could be paid to breast feed their newborn babies (Sylvester 2000) is an offer which may encourage women to continue with this healthier method of infant feeding. However, it does not force them to breast feed and they can still bottle feed if they wish. Similarly, children can be encouraged to brush their teeth by offers of stickers and posters from the dentist, if they avoid tooth decay.

Health care professionals are also justified in warning people of the probable consequences of their risky behaviour, providing that the information is accurate. Patients can still decide whether to change their unhealthy behaviour or ignore these warnings. However, doctors and nurses should not give exaggerated or false information in order to frighten people into changing their lifestyles.

5.5 Legal Prohibition

Finally, I will examine whether the legal prohibition of certain activities can be justified. The law in this and many other countries strictly regulates the use of certain addictive drugs such as cocaine, heroin and ecstasy, so that use by the general public is prohibited. The legislation is based on the belief that the use of these drugs is harmful both to those who use them and to the wider community as a whole. There are recognized health hazards for those people, who take addictive drugs, and there are also problems for society in the form of increased health care costs and arguably an increased rate of drug related crime. If the law prohibiting the use of cocaine, heroin and ecstasy was changed to allow the use of these drugs, it is argued that there 'would be a sharp increase in use, a more widespread degradation of the human personality, and a greater rate of accidents and violence' (Wilson 1997: 308).

There is a further argument to justify the prohibition of addictive drugs which alleges that the 'addict' is not acting according to his or her own free will because of the very nature of these drugs. Addicts have limited free choice - they are driven to take the drugs because of physical dependency. It can therefore be argued that the total prohibition of these drugs will actually protect the future autonomy of the person who might begin experimenting with addictive drugs, at a very young age.

Nevertheless, it has to be recognized that the law prohibiting the use of addictive drugs by the public restricts the freedom of individuals to act as they might wish, and liberals, who uphold the ideal of individual liberty, may not support such a restriction. Gordon Graham argues persuasively against the prohibition of addictive drugs (Graham 1992: 28-35). He maintains that there is little evidence to show that a change in the law to permit drug taking would lead to large numbers of people using the addictive drugs with the predicted widespread harm. He claims that much (though not all) of the

resulting harm will be direct damage to the welfare and prospects of the drug addicts themselves. It appears that the law is acting in a paternalistic manner towards those individuals who choose to indulge in taking these illegal drugs.

Indeed, the precise nature of the harm caused by some of the prohibited drugs, such as cannabis and ecstasy is not clear, and adverse long-term physical and psychological effects on the addict are not conclusively proven.⁷ In addition, the law is inconsistent since the use of nicotine and alcohol are not outlawed and yet there is convincing medical evidence to demonstrate the potential physical long-term harms for the individual who smokes⁸ and / or drinks⁹. There is also evidence to show that passive smoking, especially for children, causes a range of adverse effects including lung cancer and sudden infant death syndrome (Royal College of Physicians 1992).

Graham also questions the claim that drug taking is accompanied by an increased rate of crime. Even if it is reported that the level of drug offences and related crime are the most widespread form of serious crime in Britain (Tonks 1992: 269), Graham proposes that such statistics should be examined closely since drug taking itself is a crime. Thus, it is inevitable that there will be an associated rise in overall crime figures.

Goode (1997: 10) makes the point that drugs are sometimes classified by the law: the

⁷ Strang, Witton, and Hall (2000) state that substantial public investment for further research into the long term use of cannabis is needed to determine the physical and psychological effects.

⁸ Health Education Authority *Fact File, Smoking and Young People* HEA 1993

Doll R. Peto R. and others Mortality in relation to smoking: 40 years' observations on male British doctors *British Medical Journal* 309, 901-911

Evans A.E. Mathewson Z.M. 'Risk factors in cardiovascular disease' *Science Progress* 70, (4) 489-504

'In 1991, the Centres for Disease Control estimated that tobacco smoking causes or significantly contributes to over 430,000 deaths in the United States annually.' Goode E. *Between Politics and Reason The Drug Legalization Debate* Contemporary Social Issues St. Martin's Press 1997: 27

Royal College of Physicians *Smoking and the Young* Royal College of Physicians 1992

⁹ Working Party of the Royal College of Psychiatrists and the Royal College of Physicians (2000) suggest that while there are no deaths attributable to cannabis, there are about 30,000 deaths annually due to alcohol. Cited in Pelosi (2000: 885)

drug is described as legal or illegal. The so-called drug problem focuses on the illegal drugs, but often fails to include alcohol or nicotine, even though the latter substances may cause greater physical harm than drugs such as marijuana, and are known to be addictive. Goode criticizes the 'legalistic' definition because he claims that it creates an artificial distinction where there is no natural or pharmacological distinction between say nicotine and the drugs, which are illegal. If drugs are defined by their illegal status then there will be an increase in crime merely because people use the drugs.

Graham speculates that if addictive drugs were legalized they might become cheaper and the need for associated crimes such as muggings and burglaries might be reduced. The illegal status of drugs may therefore be a major factor in their causing social harm to others (Graham 1992: 33). Decriminalizing drug use might also reduce the costs of policing¹⁰ and prevent the corruption and violence associated with the vast profits made by some dealers. If drugs were legalized regulations to control the content and concentration of drugs could be introduced to protect users from the dangerous products often sold on the streets. In these ways the decriminalization of drugs could actually reduce the harm for both the users and the wider community.

Graham presents a further argument against the legal prohibition of certain addictive drugs. He proposes that if the legalization of drugs would lead to widespread use by large numbers of the public there is a further problem. If people would choose to take these drugs in the situation where there was no prohibition, it follows that any legislation to prohibit their use is certainly an infringement of the freedom of individuals on a considerable scale (Graham 1992: 29). Even if the use of addictive drugs such as ecstasy, heroin or cannabis is foolish, hedonistic or physically dangerous

¹⁰ Pelosi (2000: 885) claims that 'in 1997 three quarters of the United Kingdom's estimated £1.4bn expenditure on tackling drug misuse was spent on national law enforcement and efforts to lessen international supply'

for the individual, those who adopt a liberal approach may not support a legal prohibition of such drugs.

Graham has demonstrated the difficulties in justifying the legal prohibition of drugs on the basis of limited evidence of the resulting widespread social harm. Cudd (1997: 309-319) presents a similar argument suggesting that since the use of addictive drugs does not really harm others, we should legalize many drugs that are currently illegal. Yet many of the addictive drugs remain illegal both in this country and in the USA. We should therefore question whether such a policy can be justified on paternalistic grounds.

Paternalistic interventions may be justified if the decisions to be made are substantially irreversible. If people choose to use addictive drugs then it may be difficult to return to former behaviour, so that they may not have a chance to benefit and learn from their mistakes and the dye may be cast by early decisions. In the case of both drug use and smoking there is a risk that the young may be attracted to the behaviour and influenced by peer group pressure, and it is surely permissible to protect them from starting such potentially addictive behaviour.

In addition, Goodwin (1997: 321-325) argues that most people do not have one overriding preference; rather they have a variety of preferences, which can change over time. Some of our preferences conflict with others, as in the case of the individual who wishes to smoke (or take other drugs) for the immediate pleasure and relaxation that it provides, but also wishes to stop smoking in order to increase the chances of staying healthy. In this example, people may start off holding the first preference (to continue smoking) and yet there may be good reason to suppose that in the future they may develop a preference for the latter goal of ongoing health, particularly if they become ill.

Is legislation banning the use of certain addictive drugs an example of permissible paternalism? Despite the short term pleasure of drugs or smoking the vast majority of users probably express a desire to stop the habit but find it difficult to stop once they have started the addictive behaviour. It might therefore be justifiable to legally prohibit these drugs in order to prevent the young and susceptible from starting the habit which we know is difficult to break.

There are other legal restrictions, which are justified even though they limit the freedom of the individual. Most liberals accept various restrictions on individual liberty including speed restrictions on the roads, compulsory wearing of car seat belts and motor cycle helmets, and local policies introducing fluoridation of the water supply. These measures have been effective strategies for improving the health and welfare of both individuals and the community as a whole, but the potential loss of individual freedom to choose alternative options should be recognized. In addition, such policies allow the government to impose one set of values (the promotion of health and well being), rather than allowing individuals to make their own choices about preferences.

So when is complete prohibition of an activity justified? Firstly, the total prohibition of activities or the use of substances should only be a last resort, adopted when other strategies for health promotion / protection have been found to be ineffective in changing the behaviour of individuals. It is preferable to adopt educational strategies where individuals are allowed to make choices based on their own priorities and goals if it is possible. Secondly, it is necessary to have convincing evidence of the potential harms both to the individual, and more importantly to the wider community, before prohibition is justified and implemented in practice. Finally there should be general agreement in the community that the prohibition will result in benefits which outweigh the potential infringement of personal liberty and any other associated risks.

The law introducing the compulsory wearing of seat belts can be justified on the basis that there had been extensive education about the benefits of wearing belts with little evidence of behaviour change. In Britain the law was passed in 1965 to enforce car manufactures to fit all new cars with front seat belts. There was extensive publicity and education about the benefits of wearing these belts, including the clunk click television campaign with Jimmy Saville, but it was estimated that only approximately 20% of the population actually wore their belts during the 1970's. After repeated attempts to introduce legislation an act was finally passed in 1981 to make the wearing of seat belts compulsory. This law was justified on the basis that seat belts had been shown to be highly effective in reducing death and serious injury. There were not only potential dangers for the individual in a crash but there were also harmful implications for the community as a whole. Increased hospital costs, the prolonged care of physically dependent casualties or even the death of close relatives or friends were all potential harms. It is also relevant to note that the inconvenience of wearing a car seat belt is minimal and does not affect the overall goals or lifestyle of the individual.

In conclusion, there are circumstances where it is justified to limit the freedom of individuals by prohibiting certain behaviour, both for their own good and for the good of the wider community. The government, or other agencies, should attempt to promote the health of the community with legislation since health is a fundamental asset which contributes to the overall well-being of each person and society as a whole. Total prohibition of certain activities, which are known to be a high risk to health, can be justified but the loss of individual freedom should always be recognized. However, where there is inconclusive evidence about the effects and outcomes of health related behaviour, people should be able to choose other priorities and goals besides health promotion and long life.

5.6 Is paternalism justified in health care?

I have previously argued that health is valuable for the individual but other things are also valuable and may be preferred; people should be able to choose from their own values and determine their priorities, in matters which primarily affect their own lives. For example, a businessman may choose to pursue a high stress job, smoke and eat too much of the wrong things, and take little or no exercise, which will inevitably increase the chances of ill health in the future. Nevertheless, competent adults have a legal right and arguably a moral right, to refuse lifesaving treatment, and can discharge themselves from hospital: life does not have to be preserved over competing values.

In essence, people should be free from coercion or legal restrictions, and be able to choose from their own competing values, providing that their actions do not harm others. This idea is expressed in the much quoted phrase of John Stuart Mill: ‘the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant’ (Mill 1912: 15). In relation to health promotion, this implies that paternalistic interventions to protect the health of competent adults for their own good cannot be justified. Mill makes the point that this doctrine is not meant to apply to children or those people (with for example, learning difficulties), who require ongoing care and must be protected from their own actions as well as external injury.

However, Mill has no objection to vigorous persuasion, remonstrance, reasoning, entreating or education to encourage individuals to adopt the good and better ways of life. Indeed he suggests that we should seek to influence the behaviour of one another

provided that individuals are ultimately allowed to make decisions about their own actions, in matters which primarily concern themselves. It is also acceptable to criticize those people who do not adopt sensible behaviour and are unable to resist temptation, or are foolish. We can avoid the man who behaves in a way we do not admire and Mill suggests it may be our duty to caution others against the man who presents an example which may have a pernicious effect on others (Mill 1912: 95).

According to Mill, the person who cannot restrain himself from 'hurtful indulgences' may legitimately suffer 'severe penalties at the hands of others for faults that directly concern only himself' (Mill 1912: 95). He may be criticized, ostracized, left to bear the consequences of his behaviour. If he wishes to adopt behaviour, which harms his health, this is primarily his concern and society should not impose restrictions on his liberty in order to compel him to adopt a healthy lifestyle. People can however, make their views known and express their displeasure; indeed there may be an obligation to warn others of the dangers and possible consequences of certain behaviour.

To illustrate his argument, and the underlying principles, Mill examines various practical examples including drunkenness which he suggests can be injurious both to happiness and the development of the individual. Nevertheless, Mill proposes that any law which prohibits the sale of alcohol, (and thereby restricts its use), is 'illegitimate interference with the rightful liberty of the individual' (Mill 1912: 110). Each person is the proper guardian of their own health (Mill 1912: 18), and if people choose to drink excessively, this is primarily their choice.

In addition, Mill examines the consequences of excessive drinking and states that 'No person ought to be punished simply for being drunk, but a soldier or a policeman should be punished for being drunk on duty' (Mill 1912: 100). If, and only if, there is a foreseeable risk to another individual, or the wider public, legal restrictions and

possible sanctions are morally justified. Mill argues that certain restrictions on behaviour are morally permissible, if they protect other members of society from harm. In practice today, there are laws which limit the freedom of individuals in order to prevent risks to the health of others; legal restrictions on drink /driving, and restricted smoking policies are obvious examples. There are also legal requirements for business and manufacturing industries to restrict harmful pollutants and maintain a healthy working environment.

In conclusion, health care professionals should recognize the inherent ethical problems of paternalism - people should not be coerced, or forced by legal prohibitions, to adopt a healthy lifestyle for their own good. If patients choose to take risks with their health, ignoring health education and warnings, then this is ultimately their choice, because health is only one of many values for the individual. However, health care professionals may attempt to persuade, support, enthusiastically encourage and cajole their clients to adopt a healthy lifestyle, provided that they recognize that the final decision belongs to the individual. Where behaviour may result in foreseeable harm to others, it may be justifiable to restrict the liberty of individuals, but this is not paternalism.

Chapter Six

CAN A POLICY, WHICH TAKES ACCOUNT OF LIFESTYLE IN THE DISTRIBUTION OF HEALTH CARE, BE IMPLEMENTED IN A JUST WAY?

- 6.1 Problems inherent in any policy, which seeks to distribute health care resources according to lifestyle
- 6.2 Should Rationing be Implicit or Explicit?
- 6.3 The Mechanisms of Rationing
- 6.4 Alternative Policy Options

6.1 Problems inherent in any policy, which seeks to allocate health care resources according to lifestyle

In Chapter Three, I discussed four contemporary approaches to distributive justice and concluded that they did not preclude the allocation of health care resources according to lifestyle in principle. If it is not wrong in principle, it may still be wrong in practice, because it may be impossible to introduce a fair and workable system. In this chapter, I wish to explore whether it is possible to implement a policy, which adopts previous lifestyle as one of the criteria in the allocation of health care resources, in a just way, so that individuals are treated fairly.

In the first section, I will suggest that there are problems inherent in any policy, which seeks to include lifestyle as one of the criteria in the distribution of health care resources. There are difficult questions to answer: Who should be held responsible for their behaviour? How do we avoid the problem of victim blaming? What behaviour should be included in the policy? Where do we draw the line between risky but acceptable behaviour and risky but unacceptable behaviour? Who is in a position to assess the lifestyle of others? How do we avoid unacceptable intrusion into private lives?

I will go on to examine whether decisions about rationing should be implicit, and clouded in the veil of clinical judgement, or whether they should be explicit and open to public scrutiny. Finally, I will discuss the various forms of rationing, which might be implemented and an alternative policy option, which could be implemented in order to make individuals contribute to the costs of future possible health care, by paying taxation on certain products, such as cigarettes, sporting equipment, and fast cars.

In practice, it is evident that some doctors do consider lifestyle, and behaviour such as

smoking and alcohol consumption, relevant to decisions about who should be allocated scarce medical resources. If people make choices that result in illness, or injury, and a corresponding need for health care, then they should be expected to bear the consequences. In other areas of our life, individuals are judged to be responsible for their behaviour and will be expected to account for their behaviour and accept what follows.

Yet there appear to be several problems in implementing a policy, which adopts lifestyle as one of the criteria for rationing limited health care resources. Can we identify the individual who is responsible for their lifestyle and subsequent health care needs? Are we certain that the individual made an informed and uncoerced decision to adopt an unhealthy lifestyle? Consider the example of smoking; are we really convinced that the person who smokes has made a voluntary choice? The young may be unduly influenced by group pressure, while older members of society were brought up in an era when smoking was portrayed as sophisticated, both by the media and in widespread advertising. Smoking is known to be addictive¹ and for many individuals with particular personalities, it may be difficult or impossible to break the habit once established. We should not blame people for behaviour, which is beyond their control.

Behaviour is obviously influenced by social and cultural forces. Advertising campaigns actively seek to influence our choices. Our lifestyles are related to family values, group norms and socio-economic factors and it may be very difficult for people to make healthy decisions in situations of deprivation and poor education. The requirements of a healthy diet, including fresh vegetables and fruit and wholemeal bread, may be more expensive than alternatives and difficult to store in some circumstances. In addition, many people want to make healthy choices but are impeded by circumstances or personal characteristics that they cannot control, or can

¹ Royal College of Physicians (2000) described nicotine as 'a powerfully addicting drug on a par with heroin and cocaine. Further discussion on the notion of nicotine addiction will take place in Chapter 7

only control with great difficulty.

While I have argued that individuals can and do make voluntary choices about some of their behaviour, it may be difficult to assess whether the behaviour of an individual is voluntary in a particular case. Voluntariness is a matter of degree and we may have some doubts about whether the individual really could have chosen to behave in a different way. If personality characteristics or cultural environment have influenced the available choices for the individual, we should be cautious about any policy, which apportions responsibility and blame and might potentially limit access to medical care.

Daniels (1985: 158) suggests that one of the central worries about life-style choices is that they are not ‘clearly *voluntary* or are not ones for which we feel comfortable ascribing full responsibility, even if there is no way to claim diminished decision making competency.’ The dividing line between voluntary and involuntary acts is not precise and there may be a tendency to draw too sharp a distinction, which does not reflect reality. Even if an act is within the control of the individual, and therefore classified as voluntary, it may be influenced to such an extent by factors which are not within control of the individual, that we are reluctant to hold the individual responsible for the behaviour.

A policy to ration health care according to previous lifestyle has the potential to lead to victim blaming, with the emphasis focusing on individuals and their behaviour, rather than the wider environmental, cultural and social causes of disease. Lifestyle cannot be isolated from genetic, environmental, psychological and many other contributing factors. Childress (1982: 205) suggests that the ‘results of the “natural lottery”, societal practices, and individual choices may be impossible to dissect’. In reality, only a proportion of smokers will develop cancer and individuals who succumb are unlucky. While they may have chosen to smoke, they did not choose to get cancer, although it

does appear they have entered a lottery where there are increased chances of succumbing to a variety of diseases. Those individuals, who actually become ill, may deserve our sympathy and help, rather than our blame.

There is a risk that the government and public may underestimate the influence of other sources of illness such as unsafe working conditions, environmental pollution, and the effects of commercial advertising. An emphasis on individual responsibility for health might lead to reduced concern and expenditure on the wider environmental factors which contribute to ill health. This would have adverse implications for everyone, including those individuals who took minimal personal risks.

For example, an increased emphasis on attempts to change the behaviour of individuals through health education may detract attention from the collective responsibility of society to minimize the causes of death and disability. The car and tobacco industries have an enormous impact on our lives and increased statutory regulations in relation to safety, speed and advertising might have a greater affect in reducing premature death than campaigns aimed at the individual.

However, it should be recognized that while we may favour a policy in health care, which does not attribute blame to individuals, for their former behaviour, this contrasts with other areas of justice in our society. We do, for example, hold people responsible for their behaviour in areas of criminal and civil law. Judgements in the courts reflect society's belief that people are responsible for their decisions and behaviour. The driver who is found to be drunk will be punished accordingly. There will be little or no discussion as to whether the drinking resulted from social pressures, personality characteristics or even addiction. Drunk drivers may not in reality always have accidents or cause harm to others, but they will still be held responsible and punished for their behaviour, because they have broken the current law. People who do not put

on their seat belts in a car will be held responsible and if they are injured in an accident, compensation will be significantly reduced.

Why should the consequences of health related behaviour be treated differently from the consequences of behaviour in other spheres of life? The answer to this question may be partly related to the attitude of society towards those who get ill. We do not generally think that people deserve to get ill and those who are unlucky and do become ill, deserve our sympathy. It is wrong to blame these people and we may rightly feel uncomfortable about the punitive tones of refusing treatment to individuals, even if they have indulged in certain unhealthy behaviour, or known risks.

When people indulge in unhealthy behaviour, they may be imprudent and unwise but they are not breaking any laws or widely publicized rules. They may of course have disregarding guidelines and warnings about the potential risks to health, but this is not the equivalent of driving having consumed excess alcohol, or taking certain addictive drugs, where the activity is illegal. This leaves open the question of whether some unhealthy behaviour should be made illegal, or an explicit disqualifier for access to medical treatment. Yet, it might be difficult to identify which behaviour should be made illegal.

For example, there has been some debate about whether boxing should be made illegal in order to protect those people who partake from potentially serious head injury. The British Medical Association (1993) has proposed that boxing should be criminalised, on the basis that it is an uncivilised and immoral cause of intentional, deliberate, undesirable and unnecessary damage to people, especially their brains. However, Warburton (1998) has argued that even though boxing undoubtedly entails risk, both acute and chronic, of brain damage and even death, many other sports and personal

activities also entail risk, and yet the BMA is not proposing to criminalise these.² The BMA should take a consistent approach to sports and if they propose a ban on boxing, then it follows that they should also ban other sports where there are equal, or greater, dangers for the participants. If boxers are really made aware of the risks, and if children are not allowed to partake, it is difficult to justify a ban on this sport, while ignoring other sports with similar risks.

Boxing may be a special case because the injury is not only foreseeable, but also intended. Gillon (1998) suggests that there may be arguments to justify changing some of the practices of boxing, even if it is not legally banned. Safety measures could be developed to protect the individual from actual and potentially major physical harm, including a ban on blows to the brain or the compulsory use of protective headgear. Such measures would allow people to continue to pursue a sport of their choice, while protecting them from the deliberate infliction of physical harm.

It is difficult to determine which behaviour should be included in any policy, which seeks to take lifestyle into account within the distribution of health care resources.

While we can estimate how many cigarettes an individual smokes, and excessive eating can be monitored by weight checks, other unhealthy behaviour cannot be monitored so easily. For example, should we include behaviour such as unprotected sex, excessive sunbathing, and a sedentary lifestyle in the policy? Those people who indulge in such activities are taking risks with their health, but it is difficult to monitor their behaviour. Are smokers to be disadvantaged just because their habit is quantifiable?

In reality, we all behave in ways that can potentially harm our health. Driving the car

² Warburton (1998: 57) presents interesting figures from the Coroners' reports to the Office of Population Censuses and Surveys for the years 1986 – 1992, when there were only three deaths in England and Wales from boxing. In the same period there were 77 deaths in motor sports, 69 in air sports, 40 in ball games and 28 in horse riding. It is more difficult to assess chronic damage from sports, but it is clear that heavy drinking and smoking pose a far greater risk to long term health, than boxing or any other sport and yet they are not banned, although they are of course heavily taxed.

clearly presents a health risk for many people and sporting activities such as jogging, hang gliding and rugby introduce both potential benefits and risks for those who partake. It is difficult to define defensible risks as compared to indefensible risks. It might be argued that there is no comparison between smoking and driving – the former is proven to harm health, while the later is a necessity to modern life.³ However, it is impossible to draw a fair dividing line between those activities that present an acceptable risk to our health and those that do not. Value judgements and our own prejudices may be evident in our appraisal of what constitutes a ‘necessary’ risk and what is acceptable behaviour. In reality, it would be difficult to identify which behaviour should be included in a policy that allocated health care resources according to lifestyle.

In addition, if previous lifestyle is accepted as one of the criteria in the allocation of health care resources, and people are denied or given inferior health care because of former behaviour, it may gradually change our attitudes to those who take risks. Should executives, who continue to overwork and inflict stress on themselves, be penalized for taking risks with their health? In an extreme scenario, should such a policy ‘penalize’ those who do not submit to preventative and prenatal screening? If a couple choose to have a child despite indications that there may be potential health problems, will they have to pay for subsequent health care? The affects of a slippery slope should not be underestimated.

The difficulty of assessing the lifestyle of individuals introduces a variety of problems. Is it possible to distinguish between those who have had a healthy lifestyle as compared to those who have voluntarily adopted an unhealthy lifestyle? While doctors have the clinical knowledge about disease and treatment, it cannot be assumed that they will

³ Husak (1994) reminds us that driving is a dangerous activity in itself and it is not always a social necessity. Many car journeys are made for trivial reasons such as going to a party or because people do not like public transport.

have access to relevant information about the previous lifestyle of others. If the doctor asks patients whether they have taken any risks with their health, it will inevitably penalize the honest individual. In the scenario where a doctor might deny or delay life saving treatment to patients on the basis of their previous behaviour, there would be a considerable incentive for the patient to withhold information or lie. If the trust between doctor and patient is not maintained patients may be unable to divulge relevant information about their former lifestyle and subsequent treatment may not be the most beneficial.

Haavi Morreim (1995: 8) writes ‘the physician who denies medical care as a penalty for irresponsible conduct is no longer a healer with a fiduciary commitment to each patient, but an enforcer of social policy.’ If doctors were asked to make decisions about the lifestyle of their patients, in order to determine who should be allocated scarce medical resources, it might change the very nature of the relationship. Patients may lose confidence in doctors, who appear to be weighing up the cost of their treatment against that of other patients or even potential patients.⁴ Sabin (1998) suggests that doctors may have to choose between acting as excellent clinicians, by doing as much as possible for each patient’s health, and being responsible citizens who should do as much as possible for the population’s health within the available resources.

Many patients may genuinely underestimate the number of cigarettes they smoke, or the amount of alcohol they consume. The idea of monitoring the lifestyle of individuals introduces an unacceptable intrusion of privacy, and has a feel of George Orwell’s 1984 – “Big Brother is Watching You”. In practice, it will be difficult to know what behaviour people adopt in the privacy of their homes and judgements about the lifestyle of individuals should be made with caution.

⁴ Royal College of Physicians *Setting Priorities in the NHS A Framework for decision making* Royal College of Physicians of London 1995: 21

In summary, it appears that any policy to distribute health care, which includes the criterion of lifestyle, presents a number of problems in practice. Even if we accept that some individuals have voluntarily chosen to take known risks with their health, it seems difficult to determine who should be disadvantaged, if anyone, and which behaviour should be included in the policy. In practice, can doctors really be expected to make judgements about individual lifestyles without destroying the traditional trust and honesty, which underlies an effective doctor / patient relationship?

6.2 Should rationing be implicit or explicit?

In the NHS, rationing of resources has traditionally been implicit without guidelines or stated criteria. While the government sets constraints on overall expenditure and general entitlement within the legal framework, the doctor determines decisions about the allocation of resources between individual patients. Chris Ham (1995: 1484) suggests that Britain has adopted an approach to rationing that is best described as ‘muddling through.’ Politicians have historically denied that rationing in the NHS is a reality and tend to talk of setting priorities (Bottomley 1993), rather than attempting to set national guidelines about who should be treated, and which core services should be provided.

Several authors⁵ have put forward convincing arguments to support a strategy of implicit rationing. Mechanic (1992 :1722) is unequivocal in suggesting that implicit rationing offers ‘the best opportunity to allocate care effectively in the context of uncertainty, a changing knowledge base, and heterogeneity in the American population and in patterns of illness.’ He argues that professional doctors are best placed to judge which patients should receive the available resources on the basis of their individual needs and the expected benefits of treatment in each particular case. Implicit rationing allows doctors to consider the specific circumstances of cases and use their clinical discretion, rather than to be restricted by insensitive and inflexible guidelines.

Hunter (1997) has also argued that implicit rationing, or ‘muddling through elegantly’ offers the best option within a difficult and complex area. He suggests that it is an advantage if doctors make rationing decisions because the public will support decisions, which are seen, rightly or wrongly, to be clinical in character rather than

⁵ See Coast (1997), Hunter (1997), Klein (1997), Mechanic (1995), New and Le Grand (1996).

political (Hunter 1995: 878). It appears that people have generally trusted their doctors to make decisions based on the best interests of their individual patients. However, this may result in a dilemma for doctors. Doctors have a professional responsibility to provide the best possible care for their patients, according to the principle of beneficence. This may compete with the duty to be fair to other patients and potential patients by promoting cost effective care. In order to fulfill this second duty, doctors act as 'gatekeepers' to the specialist services as they attempt to keep within the budget limits of the practice or trust.

Implicit rationing may be defended on the grounds that clinical discretion is valuable because medical care is complex, uncertain and developing, and patients have different priorities and needs. In practice, doctors may prefer to inform patients that treatment would 'not be in their best interests', rather than state that resources are unavailable, so that decisions may be hidden within the context of clinical management. It may be easier for doctors to take this approach, rather than having to discuss rationing openly.

However, since 1991 and the introduction of the purchaser provider split, the so-called internal market, rationing in the NHS has become more explicit at both micro and macro levels. The case of Child B, Jaymee Bowen, and the withdrawal of the flu vaccine, Relenza from the general public, on the recommendation of NICE, have resulted in widespread media coverage, and there has been increasing awareness amongst the public that the NHS cannot do everything, (without raising taxes). Several commentators⁶ have presented arguments to suggest that rationing should be based on explicit and centrally determined national guidelines.

It is clear that decisions about treatment for individual patients are taken within the boundaries of an increasing number of guidelines from the Department of Health and

⁶ See Doyal 1997, Lenaghan 1997, Maynard 1996, Maxwell 1995

other advisory bodies such as the UK Cochrane Centre and NICE. These explicit guidelines offer certain advantages. National centres can review the available scientific data and inform practitioners of the most effective treatments so that less effective care can be withheld. The public will know precisely where they stand with regard to future entitlements to health care and can be involved in the debate about what kind of services the NHS should provide. If rationing remains implicit and hidden within clinical decisions, people may be unaware the consequences of their behaviour.

There appears to be some public sympathy for a policy, which rations health care on the basis of lifestyle. In the original rankings from Oregon, which were devised from telephone surveys and structured public meetings, a list of priorities was presented (Dixon and Gilbert Welch 1991). Liver transplants needed as a result of alcoholic cirrhosis were ranked 695 in the table. In comparison, liver transplants needed as a result of liver cirrhosis, with no mention of alcohol, were ranked 365 indicating that they were worthy of preferential treatment. This may reflect different attitudes to so called 'self-inflicted' disease as compared with those, which arise from other causes.

Of course, even if public opinion appears to sympathize with a policy for rationing health care according to lifestyle - it does not follow that it is justifiable or morally acceptable. Public opinion can be swayed by the manner of questioning, media presentation and is anyway, merely a collection of subjective views. There is no guarantee that the opinions expressed are reflective of well thought out views, based on accurate information. For example, those interviewed may be unaware of the pragmatic difficulties of implementing such a policy.

This is well illustrated in a recent study. Dolan, Cookson and Ferguson (1999) investigated the extent to which the public changes its mind about priority setting in health care following an opportunity for discussion and deliberation. Initially about

half of the respondents (sixty randomly chosen patients) wanted to give lower priority to smokers, heavy drinkers and illegal drug users. However, after discussion many of the groups no longer wished to discriminate against these people. Their findings cast some doubt about the stability of preferences.

In addition, society is made up of a number of different groups and cultures, which are pluralist in character. It is not obvious how one could access the public in order to obtain a balanced view and avoid a bias in favour of the well-articulated, middle class, or the worried well. Hunter (1995: 883) suggests there is a risk that if we move to explicit rationing and consult the public about what and who should be treated, 'less articulate and marginal groups risk being further excluded from the decision making process'.

Despite the inherent problems of public consultation, there has been an increasing emphasis upon the active participation of the consumers of health care, particularly in the recent White Paper, '*The New NHS: Modern. Dependable.*' (D.of H.1997) and the establishment of primary care groups. It is argued that in a democracy this is a desirable development.⁷ Holm (1998) suggests that the debate about rationing has shifted in emphasis from the principles of priority setting to the process of priority setting. There is an increasing recognition that it will not be possible to devise a simple set of rational rules to guide practitioners in decisions about who should be treated and what conditions should be treated. Rather, Holm suggests that in Scandinavia the debate now focuses on the priority setting process itself and its transparency.

Daniels and Sabin (1997) have argued that there must be an open process for making decisions about health care rationing and they have proposed conditions, which they claim would contribute to fairness and legitimacy in decision making. Key elements of

⁷ See Gutmann A. Thompson D. (1996) suggest that citizens or their representatives should continue to reason together in order to reach mutually acceptable decisions.

the fair process will include 'transparency about the grounds for decisions; appeals to rationales that all can accept as relevant to meeting health needs fairly; and procedures for revising decisions in light of challenges to them' Daniels (2000: 1300).⁸ Together these elements assume 'accountability for reasonableness.' The public should have access to the rationales for rationing decisions and if this process were implemented overtime, case law could be developed.

Even those who have argued persuasively for implicit rationing at the micro level of patient care, including Mechanic (1992: 1713), accept that future rationing will incorporate a 'blend of approaches.' Hunter (1997: 137) does not advocate that professionals should make decisions about resources on the basis of their preferences alone, 'especially when these are socially rather than clinically based.' Rather he is clear that there should be an overarching framework of procedural guidelines to 'structure the way in which decisions are made and ensure greater transparency' (Hunter 1997: 139). He goes on to suggest that these explicit guidelines 'would endeavour to establish a set of general principles expressing, or rather restating since they already exist, the values and objectives of the NHS and setting standards for fair and consistent administrative procedures' (Hunter 1997: 139). Within such guidelines, it would be possible to include an open and clear statement about whether lifestyle will be assessed in relation to the allocation of medical resources.

Oxfordshire Health Authority has set up a 'priorities forum' to provide advice on rationing. The forum bases decisions on an ethical framework, which focuses on three key areas: evidence of effectiveness, equity and patient choice (Hope, Hicks, Reynolds, Crisp and Griffiths 1998). The group states that there should be no discrimination on grounds of personal and social factors such as lifestyle, employment, learning

⁸ Current practice in the NHS does not always appear to meet these conditions. Ham and McIver (2000) reviewed five cases involving disagreements over treatment decisions and found that the responsible health authorities did not have an explicit process for decision making or an appeals procedure.

disability, age, race, social position, financial status, religion, or place of abode.

In The Netherlands, a report by the Government Committee on Choices in Health Care (1992: 64) has explicitly stated that an unhealthy lifestyle should not be used as a rationing criterion. This Committee suggested that everyone should have access to health care when it is needed, regardless of the reason. I would suggest that the UK government should make a similar statement, so that the public will know precisely what they can expect in terms of future entitlement to care, and what, if any, behaviour will result in disqualification or delay. In addition, when decisions are explicit, and based on published guidelines, there could be a system of appeals for those patients, who feel that they have been denied appropriate treatment.

Since there is no explicit recognition in such government documents as '*The Patient's Charter*' or '*The NHS Plan*' that people will forfeit health care, if they adopt an unhealthy lifestyle, they may be unaware that they may have to change their behaviour in order to qualify for the most effective health care. If such a criterion for rationing is introduced, people should be given the information accurately so that they can make decisions about their behaviour with the relevant knowledge of future consequences. In addition, if the NHS introduced a policy to give lower priority to those individuals who were taking risks with their health, it would have to consider offering more help to those individuals trying to give up unhealthy habits.⁹

⁹ See chapter 5 for further discussion

6.3 The mechanisms of rationing

A policy for rationing health care needs to indicate which mechanisms should be implemented.¹⁰ For example, would denial of care be justified, or should we consider delay, or an inferior service, for those individuals who have taken risks? In practice, is it really possible to deny treatment to a patient who has smoked excessively and developed lung cancer?

The mechanism of denial seems unrealistic – do we really want a policy, which suggests that ill people should be turned away from the clinic or hospital doors? Health care professionals could not stand by idly, refusing to offer care to an identified person who presents with genuine medical need. The denial of health care at the time of need seems to be unreasonably harsh and reflects a meanness of spirit, which thankfully is not evident in society. Requiring people to live with the consequences of their actions could, in the scenario of denying medical care, lead to considerable suffering and even death. In some situations, there may be additional costs incurred by any delay in treatment as the disease progresses and treatment may become more difficult. There may also be risks for others who might become infected due to prolonged exposure to an infectious person.

It seems unlikely that society would accept a policy, which refused health care to those individuals who have urgent medical needs, whatever the cause. People who collapse, or have major accidents are not refused medical care in casualty. Consider other areas of our lives. There is a tremendous urge in society to rescue the lost sailor and send out the lifeboat. We do not deny sailors rescue because they have brought the crisis upon themselves. They may have made a voluntary choice to disregard the coast

¹⁰ See Harrison (1995) who suggests that a policy agenda for health care should focus on three questions: What are the criteria by which rationing should occur? What mechanisms should exist for making and implementing rationing decisions? Who should ration?

guard's warning of severe weather and potential hazards. Nevertheless, we would still attempt to rescue them if the need arose. Similarly off piste skiers have often disregarded warnings of avalanches and yet the rescue services will strive to help if the need arises, even when there is potential danger for the rescue team.

While we do not deny treatment to those with urgent medical needs, it appears that some refusals for less urgent needs are tolerated. People are sometimes denied access to fertility treatment and drugs such as viagra on the NHS. Since these treatments are sometimes for conditions, where there is disease and loss of normal function, this may be interpreted as a denial of health care. Cochrane, Ham, Heginbotham and Smith (1991) state that at present the idea of people being denied health services is very foreign to most members of the public. These influential writers also suggest that any progress down the route of denying health care has to be understood and ultimately approved by the public.

In the unfortunate scenario, where it is impossible to treat everyone who presents with medical need, and rationing of health care becomes a reality, the NHS usually offers an inferior service or delayed treatment. These mechanisms seem to be more acceptable and less drastic than denial and yet they are forms of rationing. The elderly person who is admitted to casualty with a suspected myocardial infarction may be transferred to the general medical ward, instead of the more specialist coronary care unit. A deliberate choice can be made to deny an expensive and effective treatment in favour of a cheaper option, even though it may be less effective, because of limited resources. Choices about drug treatment can be made in a similar manner, and should be recognized as rationing.

The use of waiting lists in a number of clinical specialties is widely accepted. Anecdotal accounts suggest that certain individuals – those who smoke or drink

excessively – may be given low priority on waiting lists. We should however be cautious in assuming that the delay in treatment is solely attributable to judgements about previous lifestyle per se. Many potential patients will have to wait for considerable time, sometimes months, before specialist treatment such as cardiac surgery or liver transplantation is available. Doctors might argue that those patients with the highest probability of good rehabilitation will be chosen in preference to those individuals who have increased risk factors, such as a history of smoking or alcoholism.

Any mechanism to ration health care according to lifestyle, including denial, delay or dilution, is contrary to the stated principles of the NHS, where it is emphasized that medical care is allocated according to need and need alone. To deny health care for acute illness at the time of need is callous. However, it is important to recognize that deliberately offering a second class service or delaying treatment, is a form of rationing and we should be wary of implementing such mechanism for certain individuals who have adopted unhealthy lifestyles, because of the practical problems of determining who is responsible for their behaviour.

6.4 Alternative Policy Options

While it may be acceptable to ration health care according to lifestyle in principle, I have suggested that this cannot be implemented without potential practical problems. There are alternative policy options though, which could be implemented, and may be fairer to those involved. People might be asked to pay for treatment at the time of need, if they had indulged in certain high-risk activities. Indeed, all car drivers are currently expected to pay a small contribution to their medical care and will be charged accordingly if they are taken to a NHS casualty department by ambulance.¹¹ Since the insurance company usually pays this charge, people have not expressed undue concern. Yet only car drivers are expected to pay this charge and anyone who arrives in casualty following an accident on a bicycle, or at home, will not have a similar levy imposed. This appears to be a charge for those individuals who choose to travel by car.

There are problems with a policy to charge individuals for health care costs, at the time of need. Firstly, what happens to those people who are unable to pay? Such a policy would disadvantage people without money or insurance and cause potential hardship for the poor. This is contrary to the stated principles of the NHS, which is to provide the best possible care for all, regardless of the ability to pay.

Secondly, it would be essential to identify clearly which behaviour would be associated with charges. This may in reality present further classification problems. If a charge for horse riding was imposed, it might be necessary to distinguish between the sedate rider in the countryside and the cross-country competitor. There are certainly different degrees of risk. One person may be an occasional smoker, while another may smoke forty a day. Are they to be treated in the same way?

¹¹ See Montgomery 1998: 55. The Road Traffic Act 1988 expressly permits charges to be made in relation to treatment after road traffic accidents.

Veatch (1980: 51) and Le Grand (1991: 120) suggest an alternative policy option, which is more plausible and is reflected in current practice in the United Kingdom. Additional tax could be levied on those products, such as cigarettes and alcohol, and specialist sporting equipment, which are proven to be a risk to health. Tax could be calculated at a rate to cover the extra costs of the anticipated future care. Even if some individuals died prematurely in middle age, as is often the case for smokers, thereby saving money from long term care, the calculations of tax will be an estimate of future collective costs for all smokers, rather than an estimate of the eventual costs for the individual.

It might be suggested that taxation on certain products, such as cigarettes and alcohol, reflects a value judgement about what constitutes 'good' behaviour. We do not tax the sports player who takes risks, or the sexually active person who chooses to ignore advice about safe sex. Even if we wished to impose such taxes, it would be difficult in practice. Nevertheless, the fact that it is impossible to tax all unhealthy behaviour in a fair manner is no reason to refrain from doing so in a few obvious cases – cigarettes, alcohol, and fast cars. But there is a need to ensure that prejudices do not become evident in our policies.

Individuals, who are responsible and make the effort to maintain a healthy lifestyle, and avoid unnecessary risks, may resent having to subsidize those individuals who are more reckless. Gutmann (1995: 113) poses the following question 'Is it unjust to constrain access to medical care by making it more costly to people who voluntarily take unnecessary risks with their health?' In insurance based systems, such as the USA, where people pay contributions towards their future health care costs, it is possible to increase the levy for those who adopt risky behaviour, such as smoking, or eating excessively. In the NHS, where resources are derived from general taxation and entitlement is universal, money can still be raised from certain individuals, by placing a

tax on those products, which are deemed to be a risk to health. In this way, those individuals who partake in certain activities can be made to contribute more to the health care budget. These practices indicate that we do consider people responsible for some of their choices about health related behaviour.

In conclusion, people should not be denied health care at the time of need because of their lifestyle. If resources are limited and choices have to be made between competing patients, then a number of considerations are relevant. These should include an assessment of medical need, patient choice and the predicted clinical and cost effectiveness of treatment.¹² Previous lifestyle should not in itself be considered as a criterion because in many cases the individual may have had limited options and it is difficult in practice to evaluate who is responsible for their lifestyle choices. It should, however, be recognized that certain habits, such as smoking and overeating, may have a detrimental affect on the clinical outcomes of health care and doctors may for this reason decide that lifestyle is one of the criteria to consider when allocating scarce resources.

Many of us may remain concerned about the escalating costs of health care and may feel intuitively that those who choose to partake in activities which are known to be a risk to health should contribute to the resulting financial costs. People who choose to take risks with their health can harm others indirectly by using limited medical resources and increasing the costs of health care for everyone. The imposition of a tax on certain products known to have a detrimental effect on health would therefore appear to be fair, so that people who partake have to contribute financially towards the anticipated costs of their behaviour. Not all of these people will require health care, but those who are unlucky and become ill, should then be treated without resentment at the time of need.

¹² See chapter 2

Chapter Seven

CASE STUDIES

- 7.1 Should smokers have equal access to health care alongside non-smokers?
- 7.2 Should alcoholics and non-alcoholics compete equally for liver transplantation?
- 7.3 Should sportsmen and women contribute to the costs of treating their injuries?
- 7.4 If competent patients do not comply with prescribed treatment, should they forfeit future care on the NHS?
- 7.5 Should 'lifestyle drugs' be prescribed on the NHS?

7.1 Should smokers have equal access to health care alongside non-smokers?

In May 1993, it was reported that doctors at two of the country's biggest heart centres were refusing to perform life saving operations and investigations for smokers, unless they gave up the habit (Rogers 1993: 1). That same year, Harry Elphick, died aged forty-seven, having been refused cardiac surgery following a heart attack. He was advised to enrol in a 'smoke-stop clinic' prior to being reassessed for treatment at a later time (Butler 1999: 52). He died having given up smoking while waiting for the reassessment.

There are three arguments to support a surgeon's decision to delay treatment until patients have changed their behaviour and given up smoking. Firstly, resources are limited and should be allocated to those patients where the best outcomes are predicted. Underwood and Bailey (1993:1047) describe the potential risks of performing coronary artery surgery on patients who continue to smoke, including higher incidence of immediate postoperative complications and increased risk of atherosclerosis and vein graft failure. While reoperation is sometimes possible, it is more expensive and will obviously take yet more resources from other patients who are waiting for treatment. Underwood and Bailey (1993: 1047) claim that 'Patients who smoke spend longer in hospital and have poorer results from surgery than non-smokers. Treating them deprives patients who have never smoked or who have stopped smoking of more efficient and effective surgery.' This argument is forward looking and suggests we should treat those patients where the best results are expected.

Secondly, delaying treatment for smokers may be an effective way of persuading them to give up this harmful behaviour. Christopher Ward, a consultant cardiologist, who

promoted a policy that smokers should not be treated until they had stopped smoking, justified this approach by stating that 'It's a good way to persuade them to give up.'¹

Indeed the British Medical Association issued a press statement, which stated that 'For some conditions giving up smoking can be the best immediate treatment'²

Thirdly, it may be suggested that the illness and increased risks of surgery for smokers are self-inflicted. Smokers have, by their own choices to smoke, contributed to their illness and they do not deserve to be treated as quickly as non-smokers - they must live with the consequences of their behaviour. This argument suggests that smokers should not be given priority because of their past behaviour.

However, there are problems with these three suggestions. Firstly, cost effectiveness and the efficient use of resources is not the sole criterion for the distribution of medical resources. When we are assessing the patient - smoker or non-smoker - for treatment and possible surgery, increased risks or lower success rates should not always be an indication to withhold or delay surgery if there are still net benefits for the particular patient. Smokers may have less to gain from the surgery than non-smokers, but there will still be some gain. Higgs (1993: 1049) comments that medical science is based on probability – good guesses and perhaps no more. It follows that some smokers will defy probability and may do well following surgery.

Smoking is one of many risk factors, which will increase the incidence of complications of coronary surgery. But smoking is not a guarantee that there will be increased mortality and morbidity, and some individuals who smoke may be physically fit, young and lucky. If decisions are made with too much emphasis on the predicted outcomes of treatment, patients, who have known risk factors, and a higher incidence of

¹ Cited in Rogers L. 'Hospitals refuse to operate on heart patients who smoke' *The Sunday Times* May 23, 1993: 1

² British Medical Association 'Equal Access to NHS treatment Press release' 13 January 1994 Cited in Dawson (1994)

complications including women, the elderly, those who are obese or have existing disease such as diabetes, will be given low priority. This appears to discriminate against certain people on the basis of factors, which are not relevant to medical need and would be contrary to the current aims of the NHS, to promote equality of access to services.

Secondly, will the threat of delayed treatment really persuade people to give up smoking? There is little empirical research to suggest that such an approach will be effective and actually help people to change their smoking behaviour in the long term. As stated earlier, if the fear of lung cancer and heart disease has not deterred the smoker, then it seems unlikely that the threat of delayed treatment will now be effective. In addition, we might object to such an approach because it is coercive, with the associated loss of individual choice.³

Thirdly, is it fair to penalize smokers for their past behaviour? Do they really deserve to be given low priority on the waiting list because they have contributed to their need for medical care? Certainly they may have acted unwisely or self indulgently but they have now developed a life threatening disease. Is it justifiable to inflict further potential anxiety and possible suffering, both for the individual and perhaps for their family / friends, by delaying treatment?

Certainly if smokers had *no* choice about whether to smoke or not, and could not have behaved other than they did, they do not deserve delayed or second rate treatment. Some smokers may have some control, but still find it difficult to give up the habit. Doctors will not be able to distinguish whether smokers have no control or limited control over their behaviour.

³ Coercion has been discussed in Chapter 5, section 4.

Recent evidence suggests that many people have little or no choice about their smoking behaviour. The Royal College of Physicians of London (2000: 87) emphasizes that cigarette smoking should be understood first and foremost as a manifestation of nicotine addiction. This report, '*Nicotine Addiction in Britain*', presents convincing data to support their claims. When people try to stop smoking, the rates and patterns of relapse are similar to heroin, cocaine and alcohol. Approximately 25% of people will relapse within 2 days of their last cigarette and approximately 50% within one week (Royal College of Physicians 2000: 97). Even with the onset of certain life threatening diseases, such as lung cancer or heart attacks, the majority of smokers are unable to stop smoking completely in the year after diagnosis. Despite medical and nursing support, and even when the smoker appears determined to stop smoking, these figures remain constant.

But what does it mean to say that the smoker is addicted to nicotine?⁴ The Royal College of Physicians (2000: 83) uses the term to describe the 'situation in which a drug or stimulus has unreasonably come to control behaviour.' According to Goodin (1989) the test of addiction is not whether it is impossible to give up the behaviour, but rather the difficulty of withdrawal. Many people have given up smoking, but for some people, perhaps those with addictive personalities or certain inherited traits, it may be virtually impossible to give up. If the desire to smoke is so strong that even those people with 'normal' and 'reasonable' self-control cannot resist the temptation,⁵ we should recognize that it might be virtually impossible for some people. People do have the capacity to say 'No' to the next cigarette, but for some, saying 'No' may be more difficult. This may be reflected in the idea that many people would rather not smoke and yet they find it very difficult to give up.

⁴ According to the World Health Organisation, drug addiction is a psychic or physical stage resulting from the interaction between a living organism and a drug, and characterised by behavioural and other responses that always include a compulsive desire to experience its effect and/or avoid discomfort of its absence. Cited in Oommen (2000)

⁵ There is increasing evidence that there is a physical link between particular receptors in the brain which tend to generate compulsive or repetitive behaviour

Smoking prevalence in the United Kingdom has stabilized at one in four of the adult population with much higher levels in the deprived sections of society. Although two thirds of smokers want to quit and about a third try each year, in the last ten years, long-term cessation rates amongst middle-aged smokers have averaged around 2% per year (Royal College of Physicians 2000: 122). The report concludes that once dependence is established, the majority of smokers will continue to smoke for nearly 40 years.

It is wrong to penalize smokers for behaviour, which is very difficult to control, particularly since the vast majority of people, over 80%, who become regular smokers, start smoking as young adolescents in the United Kingdom (Royal College of Physicians 2000: 101). If there is a voluntary choice to smoke or not, it will be at the point when you begin smoking, and the data would suggest that this is often at a relatively young and immature age, often under the age of fifteen. Notably, this is before you are legally considered to be mature enough to buy cigarettes in this country. The report (page 101) states ‘Decisions to smoke made in the early teens can be consolidated into addictive behaviour before the smoker reaches maturity’

Hence Professor John Britton, Chairman of the report and Professor of Respiratory Medicine at the University of Nottingham, states ‘We would like to see health professionals and the public accept smoking as a disorder that needs to be treated just like any other disease.’⁶ Nicotine addiction should be seen as a major medical and social problem and it should be treated as such. If nicotine addiction results in a medical need, then it follows that it should be treated with nicotine replacement therapy and other interventions such as the antidepressant, bupropion, and behavioural support groups, funded on the NHS.

⁶ Cited in Kmietowicz (2000)

Even if we accept that smoking should be treated as nicotine addiction and as a disease in itself, some people may still ask whether it should be treated on the NHS. The NHS provides treatment to meet 'medical needs' but does not claim to treat all disease.

Since the NHS does not always treat impotence, or infertility, which may be the result of disease, we cannot assume that the NHS will treat nicotine addiction. I have already suggested that health care resources are scarce and there will obviously be competing demands for NHS funds, and preference may be given to life saving treatments and acute services. Currently, nicotine replacement therapy is not universally available on the NHS and only certain preparations are available in some areas.

However, the NHS does recognize the importance of prevention of disease and has set out plans and immediate priorities in the recently published '*National Service Framework for Coronary Heart Disease*' (Department of Health 2000). Reducing the prevalence of smoking, and the successful treatment of nicotine addiction, could effectively reduce coronary heart disease, which is one of the biggest causes of death in this country.⁷ Hence, the Royal College of Physicians (2000: 188), Moxham (2000), and Britton (2000) suggest that nicotine replacement therapy should be widely available on NHS prescription, since it is a rational and cost effective treatment for nicotine addiction.⁸ Clinical trials confirm that the use of nicotine replacement therapy – patches, gum, spray or inhalators - will significantly increase the rate of success of smokers breaking their addiction (Cochrane Review May 1999)⁹.

⁷ More than 1.4 million people suffer from angina; 300,000 have heart attacks every year and more than 110,000 die of heart problems in England every year (Milburn A. 'Foreward by the Secretary of State' In Department of Health *National Service Framework for Coronary Heart Disease* 2000: 2

⁸ The Royal College of Physicians (2000) suggest that nicotine replacement therapy costs between £212 and £873 per year of life saved (1996 prices). This is comparable to other medical treatment available on the NHS.

⁹ Silagy C. Mant D. Fowler G. Lancaster T. *Nicotine replacement therapy for smoking cessation (Cochrane review)* In: The Cochrane Library, Issue 2, 1999. Oxford Update Software Cited in Royal College of Physicians 2000: 143

In essence, smokers do not deserve to forfeit health care on the basis of their lifestyle, because many are suffering from an addiction. Behaviour that is the result of addiction is unfortunate but not blameworthy, since it is not within the control of the victims once it is acquired. Further, this addiction is often acquired while the person is still immature, and may have unrealistic expectations that they will be able to control the behaviour. We may therefore excuse this behaviour, and we should offer support accordingly. It follows that health care professionals should treat smokers' addiction and try to prevent further disease and the need for future expensive medical care. Reducing smoking will be an effective way to improve the health of the nation and could reduce the expenditure on the acute NHS.

In addition, health care professionals should not focus exclusively on the smoker, but recognize that the fact that people still smoke could be viewed as failure of public health campaigns (Persuad 1995). It follows that health education, stricter enforcement of regulations controlling the sales of cigarettes and a complete ban on smoking advertising should be a priority, particularly where the young are involved. Warnings on tobacco products should also emphasize their addictive nature, which may be more relevant to young people than the distant risk of cancer or heart disease in later life.

7.2 Should alcoholics and non-alcoholics compete equally for liver transplantation?

The question of whether smokers should have equal access alongside non-smokers for treatment raises different issues from those of whether alcoholics and non-alcoholics should compete equally for liver transplantation. More people, including smokers, could be treated if the NHS economic budget and staffing levels were increased. However, liver transplantation involves the use of a physically scarce organ – there is a finite number of livers for transplantation, and there are not enough livers to meet current demand. Thus choices *have* to be made about which patient is given the chance of a functioning liver, while others are denied treatment, which could potentially save their lives.

The circumstances of liver transplantation also differ from those of other life saving therapies such as dialysis and kidney transplantation. Patients who have end stage renal failure can be treated on dialysis while they wait for kidney transplantation, sometimes for a number of years. In contrast, patients with end stage liver disease will die without the liver transplantation, because there is no alternative replacement therapy for failed liver function.

In view of the dire and absolute scarcity of donor livers, Moss and Siegler (1991) suggest that it is fair to hold people responsible for their choices, and to allocate donated livers on the basis of the recipient's previous choices and behaviour. They propose that alcoholics, who develop end stage liver disease, should be given lower priority on the waiting list than others who develop liver failure through no fault of their own. Hence patients who develop liver failure, from congenital disease or illness unrelated to alcohol, should be distinguished from those whose 'liver disease results from failure to obtain treatment for alcoholism' (Moss and Siegler 1991: 1296).

If we simply cannot treat all that are in need, Moss and Siegler (1991) suggest that it is fair to discriminate on the basis of former lifestyle and alcoholism because the liver failure could have been prevented if individuals had sought treatment and changed their behaviour. Moss and Siegler (1991: 1297) are not suggesting that alcoholics should be held responsible for their disease as such, but that they should be held responsible for not seeking treatment once their condition is diagnosed, so that the complications and subsequent liver disease could be prevented. These are not value judgements about the worth of different lives, but rather Moss and Siegler propose that people should be held responsible for their 'personal effort.'

Moss and Siegler (1991: 1296) state that 'Although a first-come, first-served approach has been suggested to provide each patient with an equal chance, we believe it is fairer to give the child dying of biliary artresia an opportunity for a *first* normal liver' than it is to give an alcoholic who was born with a normal liver a *second* one.

Glannon (1998: 46) makes a similar claim to that of Moss and Siegler. He proposes that it is fair 'to give lower priority to alcoholics *if* they have but fail to exercise control over the events that lead to their disease and liver failure, and if non- alcoholics with liver failure do exercise this control.'¹⁰ Glannon justifies this approach by arguing that people have sufficient control over their choices, actions and the consequences to be partly responsible for the resulting disease. Accordingly, the alcoholic has a weaker claim to receive a new liver than someone who acquires the disease through no fault of his / her own. Glannon recognizes that certain factors, such as genetic makeup and / or family upbringing, may predispose the individual to developing alcoholism, but these

¹⁰ In this statement there is the recognition that some non-alcoholics have contributed to the development of their liver failure by their choices and behaviour. For example, drug addicts who share needles may develop hepatitis B, which may result in severe and life threatening liver failure. These patients might also be given lower priority than patients who develop liver failure through no fault of their own, because they are partly responsible for their disease and subsequent medical need.

factors do not compel the individual to drink. People are still partly responsible for their alcoholism and subsequent medical need for scarce resources.

Since choices have to be made about which person is treated, and perhaps more importantly which person is not treated, there is a situation of inequality. Finite medical resources do not permit similar treatment for all cases of similar medical need in the scenario of liver transplantation. Allocating a liver for an alcoholic may result in the death of a competing candidate, whose liver failure was wholly beyond their control. In this scenario of absolute scarcity, it may be fair to include personal responsibility as one of the relevant criteria in decisions about who should be treated, and who should not be treated.

While accepting that difficult choices have to be made between patients who need liver transplantation, there are three problems with this proposal. Firstly, are alcoholics really partly responsible for their condition, and subsequent medical needs? Secondly, in practice, is it possible to assess the 'personal effort' that individuals have made to change their behaviour? Finally, medical resources are not usually allocated according to the worth and past behaviour of potential patients. Why should we introduce this criterion in the allocation of donated livers for transplantation?

If we accept that alcoholism has a physiological and / or genetic component and may be viewed as a disease, it would seem that people might have limited control over their excessive drinking, and less than those who avoid excessive drinking. It might therefore be unfair to hold alcoholics responsible for their medical needs and treat them differently from other people who have liver disease.

We should not accept that alcoholism is a moral vice, unless we know that people really do make well-informed, voluntary choices about their drinking behaviour.

People will be strongly influenced by cultural and contextual forces, which limit their personal choices. Only the very strong, or highly motivated, may be able to resist the pressures of social groups, role models and the environment. This implies that while restraint is praiseworthy, lack of restraint is not necessarily blameworthy.

Alternatively, alcoholics may be viewed as neither sick, nor bad, but as people who have developed a drinking problem through a learned habitual behaviour. Rather like the compulsive gambler, or smoker, the alcoholic may have been unduly influenced by social and psychological factors. Personal responsibility for health and illness is a matter of degree. Certain factors can be presented to wholly, or partly, excuse a person from responsibility: there may be a family history of alcoholism and a genetic predisposition towards addictive behaviour. Further, many people start drinking at a young age, before they fully understand the risks of alcohol addiction. Like smokers, adolescents may believe that they can drink now and will be able to give up in the future, before dependence and addiction become a reality. It will be difficult to assess the affects of these factors and the extent to which they undermine control and responsibility.

Secondly, in response to the proposal by Moss and Siegler, I would ask whether we really can assess 'personal effort' in practice? Can doctors, or anyone else, really know how much effort another person has made to change their drinking habits? Moss and Siegler (1991: 1297) propose that alcoholics should be held responsible for the personal effort needed to seek treatment in order to prevent the complications of their condition. Yet many alcoholics initially deny that they have a drinking problem and may find it virtually impossible to control this compulsive behaviour once it is established. Other people may find it relatively easy to give up alcohol with ongoing support and treatment. It will be impossible for doctors to make accurate judgements about the amount of effort required by an individual to overcome alcohol addiction. It

potentially places the doctor in a new role – that of lifestyle judge rather than a clinician that treats the patient to the best of his or her ability. In addition, the notion of trying to determine effort and moral strength of character would involve highly intrusive investigations and an unacceptable invasion of personal privacy.

Thirdly, medical resources are not allocated elsewhere according to judgements about the moral worth or personal characteristics of other potential patients. The car driver who recklessly drives too fast and causes an accident is not denied intensive care treatment. Criminals who deliberately harm others in violent incidents are still offered medical care according to need. Alcoholics may have been unwise, weak willed, and self indulgent, but they have usually harmed themselves more than others. Why should alcoholics be treated differently from other groups of people who behave in undesirable ways?

The scarcity of donated livers will mean that some patients die because it will not be possible to treat everyone who needs transplantation. Even so, it is not fair to penalize alcoholics on the basis of their personal behaviour and strength of character, because it would be impossible to make judgements about personal effort and moral worth in a fair and acceptable way. Doctors have the expertise to make clinical decisions, but they are not educated to make judgements about the character and personality of their patients.

Decisions about which patient should be treated with liver transplantation should be based on other criteria, such as the predicted outcomes of treatment, and clinical effectiveness. Until recently, it has been unusual for patients with alcoholic cirrhosis to receive liver transplantation. Alcoholics were given lower priority than non-alcoholics because of the medical argument that the survival rate of the former was lower than that of the latter. In addition, the alcoholic might succumb to alcohol abuse following

transplantation, which could cause noncompliance and potential complications. It was argued that scarce resources should be used to give the best results and therefore alcoholics should not compete equally for liver transplantation.

However, recent evidence suggests that this argument is no longer based on accurate information. Bird, O'Grady, Harvey, Calne and Williams (1990) have reviewed the outcomes among patients with alcoholic liver disease, who had received a liver transplant over a period of nine years. They showed that the rate of survival and rehabilitation of patients undergoing liver transplantation for alcoholic cirrhosis were as good as in patients with cirrhosis of other aetiologies. Lucey et al (1992) also demonstrated that the survival rate for those with alcoholic liver disease did not differ from that observed in non-alcoholic recipients.

Cohn and Benjamin (1991: 1300) write that the suggestion that alcoholics should not be treated because of poor outcomes 'could serve as a good reason to exclude alcoholics only if it were an equally good reason to exclude other groups having a prognosis equally bad or worse.' Yet patients with existing cancer and low survival rates are sometimes treated and it is therefore unfair to exclude alcoholics on predicted outcomes alone.

Some patients, with or without, a history of alcoholism, may have substantially lower predicted survival rates following transplantation, related to psychiatric illness, coexisting neurological and cardiovascular disease, or a poor nutritional state. If the aim is to increase the probability of successful outcomes, then it is these patients who should be given low priority rather than alcoholics per se. This argument is based on future outcomes rather than past behaviour, desert or any assessment of personal effort. I therefore conclude that both ethical and medical arguments suggest that alcoholics and non-alcoholics should compete equally for liver transplantation.

7.3 Should sportsmen and women contribute to the costs of treating their injuries?

The smoker and the alcoholic already contribute significantly to their health care costs by taxation on cigarettes and alcohol. In both these cases there is doubt about how much personal control the individual can exercise over their behaviour and yet they pay considerable sums of money to the government. This taxation can be hypothecated to fund the NHS, in order to pay for the increased costs that smokers and alcoholics, supposedly generate.

In contrast, sportsmen and women, who knowingly take risks with their health, are not made to contribute to their future increased medical costs. Unlike smokers and alcoholics, there does appear to be a strong element of personal control, as to whether the adult chooses to partake in sports such as rugby, horse riding, motor racing or boxing. If people partake in such dangerous sports, knowing and understanding the possible risks involved, should they be required to contribute to their subsequent health care costs, if they are injured? Should those who enjoy watching, and those who make money through these sports, also contribute to the future health care costs of the participants?

It would be possible to distribute the costs of health care more fairly by taxing those people who partake in dangerous sports. For example, a tax could be imposed on sporting equipment and compulsory insurance schemes could be imposed upon those who chose to partake in certain activities such as ski-ing, cross country riding or rugby. The NHS would still provide care for everyone, and would receive additional funding to treat those who have voluntarily chosen to take part in dangerous sports. The suggestion here is not to refuse sportsmen and women treatment at the time of

need, but rather to ensure that they contribute to the costs of health care resulting from risks voluntarily incurred.

Le Grand (1991: 124) has proposed a system where health care costs are met in two sorts of ways, corresponding to whether the costs result from factors within the control of the individual, or not. He writes that where people suffer ill health as a result of factors beyond their control 'they should not suffer losses in consequence; hence, they should have treatment free at the point of use and financed by the community.' In contrast, he states that 'if it were established that some activities (such as smoking), did create greater health risks than others, then a special tax should be levied on those activities, at a level sufficient to generate enough revenue to finance the extra treatment costs.' (Le Grand 1991: 123).

There is an assumption here that smoking is voluntarily adopted and I have already discussed the addictive nature of nicotine, which indicates that some people have limited control over this behaviour. However in the scenario of adults choosing to partake in dangerous sports, it seems that the choice is generally not coerced or driven by physiological needs. (There may be rare situations where people are persuaded into taking risks by the attraction of money or star status, but the individual can still make a choice.¹¹)

Nevertheless, there are some problems with the proposal that sportsmen and women should contribute to the costs of their health care. Many of these dangerous sports are promoted, both by government and schools, for their benefits: the exercise, sense of well being and enjoyment for the participants. Both participants and audience have a sense of excitement and fun, possibly associated in part with the thrill of overcoming the known risks. The sense of satisfaction at having completed the parachute jump or

¹¹ Persuasion and the ability to make choices has been discussed in Chapter 5, Section 3

cross-country course is probably related to the sense of achievement and relief at having avoided injury.

Sport and exercise are generally viewed as beneficial to health. While some sports such as boxing and riding are known to be especially risky, there are obvious benefits to the majority of participants, who will be fitter and healthier than people who do not take any exercise.

How will we draw the line between dangerous sports and those deemed to be safe? All sports entail risks: joggers can damage their joints, people who play football experience rough tackles, and even cricket players can be hit with the ball. Which sports will be taxed and which will be promoted for their health benefits? Why should boxers and rugby players be singled out for discrimination, while joggers and cricket players are allowed to pursue their chosen sport without incurring penalties or costs for subsequent health care? How dangerous does an activity have to be before we are justified in imposing a tax to ensure that participants contribute to future health care costs?

Further we all take some risks with our health. McLachlan (1995: 210) suggests that non-virgins might be asked to pay for their future sex related health care. If people choose to drive small cars, in preference to larger and safer models, should they be required to contribute to the future costs of possible injury? People take holidays abroad, which may involve exposure to different environmental risks – in preference to staying at home. Should they have to pay for subsequent related health care? Any system, which attempted to impose taxes based on such distinctions, might be unworkable. In addition, it seems likely that the public would object to scrutiny and ongoing intrusive monitoring of their private lives, which would be integral to the implementation of such taxation.

Le Grand (1991) suggests that the government should discriminate against all groups of risk takers, but in his writing he appears to focus mainly on smokers. I would suggest that it is not feasible to identify and tax everyone, who takes risks with their health, because we all take risks in different ways: driving the car, eating too much, living in a city, or indeed taking insufficient exercise.

However it would be possible to select certain dangerous sports for taxation, even if it were not feasible, or right, to tax all sporting activity. We would have to be able to justify the distinctions that we made, and ensure that our judgements were not based on inappropriate values and prejudices. We accept that the police place traffic speed checks and cameras on some roads, while ignoring others, and we do not think that this is unfair. Where the sporting risk is statistically proven, and we can impose a relevant taxation or insurance scheme, it is justifiable to do so. I say 'relevant' because it would seem wrong to put taxation onto safety equipment, such as cycle helmets, or riding hats, which might discourage their use. Rather we should place a tax on the racing car, ski-ing pass, or hang glider in order to ensure that participants contributed, to the costs of their future care, without reducing their personal safety.

In essence, it appears that the benefits of sport for the majority usually outweigh the potential health risks and possible problems that the minority will suffer. Sportsmen and women are aware of the risks, but choose to take these risks because of the potential benefits. They do not choose to become injured and will hope that they are lucky. It therefore seems inappropriate to impose a tax on most sporting activities, which will generally improve health and well being for the community. However, in principle, it would not be wrong to impose a compulsory taxation or insurance scheme on those sports, where there is a serious and proven risk to health.

7.4 If competent patients do not comply with prescribed treatment, should they forfeit future medical care on the NHS?

There are a number of patients who do not comply with prescribed treatment. For example, a smoker may refuse to attend the smoking cessation clinic; a transplant patient may not take the immuno-suppressive drugs necessary to prevent rejection; and the obese patient may refuse to diet and exercise. In these examples, there are obviously various degrees of personal responsibility. Nevertheless, if patients choose not to comply with the prescribed treatment, should they forfeit future related care?

Initially, I will consider the case for giving preference to the compliant, rather than to those patients who adversely affect the outcomes of medical care, by their choices and behaviour. People who continue to smoke will significantly increase the potential complications of surgery and consequently may require a prolonged hospital stay (Underwood and Bailey 1993: 1047). This will have implications for other patients, both smokers and non-smokers, who will have to wait longer for their surgery, sometimes with dire consequences. It therefore seems reasonable to expect potential patients for cardiac surgery to attempt to give up smoking prior to hospital admission. If patients refuse to co-operate with this medical advice, and will not attend smoking cessation clinics,¹² then it is fair to delay their treatment, and give priority to people who are expected to obtain maximum benefit from the surgery, with lower incidence of complications.

Similarly, obese patients, who refuse to diet prior to hip surgery, will increase the risks of immediate and long-term complications. They may also require a prolonged hospital stay, thereby 'blocking' beds and delaying treatment for others. It is therefore

¹² The government has made it a priority for Health Authorities to set up 'specialist smoking cessation clinics' by April 2001 Department of Health *National Service Framework for Coronary Heart Disease* 2000: 19)

justifiable to give priority to those compliant patients who will probably make a faster recovery, so that more patients can be treated.

If transplant patients do not take their immuno-suppressive drugs and subsequently reject their transplant, should they be offered a second donated organ? Is it not then fair to offer scarce organs to those patients who will comply with treatment in order to maximize the best possible outcomes and the best use of limited resources? In essence, it seems wrong to give liver transplants to patients, who have demonstrated that they will not co-operate with prescribed treatment and will place the transplant at risk.

It is important to recognize that the decision not to give priority to those patients, who contribute to their illness and need for ongoing medical treatment, is not based on the notion of punishment or an assessment of desert. Rather in these cases, it is a decision to maximize the use of scarce resources and promote the best outcomes for the majority of patients.

Even so, I have some concerns about this proposal, and wish to consider the case against giving preference to the compliant. Firstly, it may be difficult for doctors to assess whether patients are complying with prescribed treatment and it places doctors in the position of judge and manager of resources, rather than as professionals, who will do their best for patients. Secondly, we may have concerns about whether the individual who fails to comply with advice and prescribed treatment is really making a voluntary and informed decision. It is difficult to understand how anyone could sensibly choose not to take immuno-suppressive drugs and risk their transplant. Perhaps such a patient has some deep misunderstandings or even a psychological illness. In such a scenario, we would not hold the individual responsible for their behaviour and might try to offer support, and ongoing medical treatment.

Alternatively, the patient may be young and / or immature and in some cases, it may be wrong to hold them responsible for their behaviour. In a controversial case, a dentist refused to treat two children aged nine and five, because he felt that the treatment was of little value if the children's dietary habits were poor and showed no signs of improving. The British Dental Association supported the dentist's right to 'deregister' patients who did not look after their teeth (Bunting 1994: 3). The Chief Executive of the Association stated that 'Patients do have that responsibility to look after their own mouths' (Pallot and Fletcher 1994: 6). However, it seems wrong to hold such young children responsible for their poor diet and excessive sweet eating, when parents should still have a powerful influence over their behaviour. By denying the children treatment and dental education, the dentist appears to be harming vulnerable people, who are unable to understand the long-term consequences of their decisions. Even if the intention was to persuade the parents to educate and protect their children, withdrawing treatment may adversely affect the young.

Finally, in reality it may be difficult to refuse to treat an identifiable patient who is already undergoing treatment. Consider the case of Ernie Crowfeather, a bright charming part American Indian, who spent thirty months on renal replacement therapy undergoing both dialysis and transplantation. He regularly refused medication, missed treatment sessions and was preoccupied with both drugs and alcohol. The doctors involved in the case, repeatedly discussed whether to continue treatment or whether to terminate his care knowing that this would inevitably result in his death. In practice, their discussions were academic, since Ernie refused further life-supporting treatment and he died at the age of 29, having deliberately avoided contact with the hospital. The doctors involved in his treatment stated that they would literally never have withdrawn treatment, because it was foreign to their purpose and effort. The psychiatrist suggested that physicians would not have the courage to turn off the machine while Ernie was in hospital and while he suggested that this might be the right

decision, it would be difficult and distressing to explain such a decision (Fox and Swazey 1978).

Nevertheless, in cases of dire scarcity, it may be right to give priority to those patients where the predicted outcomes of treatment are favourable. When resources are scarce and we are unable to treat everyone, who needs treatment, it is right to use resources in the most efficient way possible. If patients do not consent to the whole treatment package, and refuse to comply with prescribed drugs or diet, then it may result in blocked beds, or the inefficient use of limited resources. It does therefore seem fair to give priority to those patients, who will co-operate and obtain the maximum benefit from treatment.

7.5 Should 'lifestyle drugs' be prescribed on the NHS?

Lifestyle drugs are used to improve the quality of life, rather than alleviating or curing disease or injury and are sometimes prescribed for conditions, which appear to result from personal choice and lifestyle. They include bupropion (zyban) and nicotine replacement therapy, which are used to support people who are giving up smoking; orlistat (xenical), which is used to treat obesity; and sildenafil (better known as viagra), which is used to treat erectile dysfunction. It is possible to treat these conditions without drug therapy in some cases, by encouraging people to change their lifestyle and behaviour. I wish to examine whether lifestyle drugs should be prescribed on the NHS.

Gilbert, Walley and New (2000: 1341) suggest that lifestyle drugs may be defined as those, which are used for 'non-health' problems, or for problems that lie at the margins of health and well-being. However, we should be cautious about simplifying the classification of these drugs since they can be used for different conditions, and have a number of properties, some of which can be classed as 'therapeutic' while others are considered to be related to 'lifestyle'. Ballard (2001) cites the example of hormone replacement therapy, HRT, which is therapeutic drug when used for the relief of symptoms, yet can be used for potential lifestyle benefits if it is taken to maintain youth or enhance libido. Viagra can be prescribed for the diabetic man who is suffering from the associated complications of neuropathy and erectile dysfunction, and can also be prescribed for the healthy man who is unhappy with his sexual performance. Our attitudes to whether these drugs should be prescribed on the NHS may depend upon whether we consider the drug is being used for a medical need or a lifestyle wish.¹³

¹³ Of course, the thwarted lifestyle wish may become a psychological problem which in turn can lead to mental illness and the need for medical treatment.

There are a number of arguments, which suggest that lifestyle drugs should not be prescribed on the NHS. Firstly, the NHS cannot fund unlimited health care and if lifestyle drugs are funded then it is inevitable that other treatments will be limited.¹⁴ Even if predicted costs of lifestyle drugs are exaggerated, the costs will be enormous.

Secondly, it might be proposed that people should be able to change their lifestyle and with education, persuasion and support, they should be able to control their behaviour. There should not be a need to resort to drug therapies, when changes in lifestyle can improve the condition. Indeed, conditions such as obesity, smoking and high cholesterol might be better treated by a change in lifestyle so that the underlying problem can be addressed. If people are treated with drugs then they may become dependent upon the drugs and the underlying problem will not improve. People may relapse to former behaviour when the drugs are discontinued.

Thirdly, it might be proposed that the NHS should treat medical needs only. People could choose to fund lifestyle drugs for themselves, if and when they chose. Other people would not therefore be coerced into funding lifestyle drugs on the NHS.

However, I propose that the NHS should fund some lifestyle drugs, even if the costs are significant. Firstly, the costs of failing to help risk takers may be even greater than the costs of lifestyle drugs. For example, the costs of obesity to the NHS are enormous. In February 2001, a report from the National Audit Office estimated that obesity cost the NHS alone, £485 million a year (Moore 2001). Of course, this is over and above any costs to the community of lost working days due to the associated complications, such as back pain, and the physical and psychological problems of those people who are obese. Further, obesity is a key risk factor in both coronary heart

¹⁴ Whitfield (1999: 14) suggests that there are 1.8 million men who suffer complete erectile dysfunction, and a further 8 million who suffer partial dysfunction. The costs to the NHS could therefore be tens of millions of pounds a year unless some restrictions are placed on prescriptions for Viagra.

disease and type-2 diabetes.¹⁵ If obesity is prevented, or treated, then future health care costs will be reduced. The financial costs of lifestyle drugs should therefore be balanced against the savings that can be made by preventing future chronic illness.

Secondly, it is likely that many people are not able to change their lifestyle, and will find it difficult to maintain any change. More people will successfully change their behaviour with the support of lifestyle drugs. For example, there is convincing evidence that a higher proportion of people will be able to stop smoking with the support of nicotine replacement therapy (Royal College of Physicians 2000: 143). It is probable that some people will be able to lose weight more successfully while using drugs, which reduce fat absorption, such as Xenical.

Thirdly, the NHS already funds drugs, which are neither lifesaving, nor a treatment for illness or injury. For example, oral contraceptives are widely prescribed to healthy women allowing them to plan pregnancies at their convenience. It is not consistent to deny lifestyle drugs on the basis that the NHS should only fund drugs for medical needs. Whether the NHS should fund contraceptives and abortions is of course a relevant question. I suggest, though, that the NHS is justified in funding these treatments. Firstly, the costs of supporting unwanted pregnancies and obstetric care may be more expensive than the provision of contraceptives and gynaecological services, both in terms of financial costs and personal costs. Secondly, it appears that the public supports 'family planning' on the NHS, even if it is not meeting a medical need as such.

¹⁵ The National Service Framework for Coronary Heart Disease (Department of Health 2000: 17) stresses the importance of smoking cessation and states that the NHS and partner agencies should contribute to a reduction in the prevalence of smoking in the local population. Later this year, the National Service Framework for Diabetes will be published and it seems probable that one of standards will relate to the reduction of obesity in the population.

The ongoing development of lifestyle drugs will ensure that the rationing debate continues. There will be a need to make decisions about which patients should be treated, and which conditions should be treated on the NHS. I propose that policy makers and advisory bodies such as NICE should establish explicit guidelines and emphasize that judgements about individual lifestyle and desert should not be used in the selection of who is allocated these drugs. This approach is justified because of the practical difficulties of assessing whether a person deserves treatment, and the consequences of placing doctors in the position of judge and policy enforcer, as discussed in chapter six.

However, decisions about who should be allocated lifestyle drugs will have to be made. I propose that guidelines about which conditions should be treated would be justified. For example, severe asthmatics might be prescribed anti smoking drugs; diabetics might be prescribed drugs such as xenical for obesity; and the elderly might be prescribed the anti flu drug, relenza. Those people with life threatening conditions should be allocated drugs that will assist them in adopting a healthy lifestyle in order to prevent complications.

In conclusion, I believe that a range of treatments and lifestyle drugs should be available on the NHS. A blanket ban to supply a particular lifestyle drug may harm specific patients who have clearly defined medical needs, such as the diabetic man who has erectile dysfunction. I have proposed that it is not fair to allocate lifestyle drugs according to whether patients have or have not maintained a healthy lifestyle, because of the practical difficulties of making such decisions. However, since rationing decisions will have to be made about the allocation of these drugs, it is fair to select certain clinical conditions where treatment should be allocated as a priority.

Chapter Eight

LIFESTYLE AND ACCESS TO HEALTH CARE

8.1 Conclusions

8.1 Conclusions

I have chosen to examine individual responsibility, justice and access to health care for a number of reasons. Firstly, rationing in health care is inevitable¹ and is widely acknowledged to be a global issue (Coulter and Ham 2000). As new medical treatments and lifestyle drugs are developed, and genetic screening and enhancement become a reality, the demands on health care will increase. Given that resources are limited, decisions will have to be made about who should be treated, because it will not be possible to treat everyone with the treatment of first choice. In this thesis, I have explored certain aspects of *how* to ration fairly.

Secondly, lifestyle is one of the criteria that could be used to ration health care. For example, smokers are sometimes denied immediate surgery and they may be given low priority on the waiting list. In Chapter Two, I have argued that decisions about the allocation of scarce medical resources should be based on a number of criteria including medical need, patient desire, and clinical and cost effectiveness. Where factors such as age and lifestyle affect clinical effectiveness they are also *indirectly* relevant. I have suggested that this should be contrasted to the situation where medical resources might be allocated to individuals on the basis of their former lifestyle *per se*. In this thesis, I have explored whether lifestyle is directly relevant to decisions about which patient should be treated in the unfortunate scenario, when not all patients can be treated.

Thirdly, government policy documents including '*Saving Lives: Our Healthier Nation*' (Department of Health 1999) and '*The New NHS. Modern. Dependable.*' (Department of Health 1997) have increasingly included reference to individual responsibility for health. Currently there is no suggestion that people should forfeit

¹ The inevitability of rationing is discussed in Chapter 1.

health care if they behave irresponsibly and continue to take known risks with their health. But what *should* happen if people choose to ignore government health warnings and do not adopt a healthy lifestyle? Is it justifiable to withdraw or delay related health care and give priority to those individuals who have maintained a healthy lifestyle?

Doctors and nurses occasionally blame patients for their behaviour and they may scold and reprimand patients accordingly. By doing so, it appears that health care professionals are holding people responsible for their lifestyle and blaming (even punishing) them on account of it. Advertisements from the British Heart Foundation (2001) show smoking, diet and a sedentary lifestyle as the causes of heart disease and death. The message appears to be that individuals should change their behaviour in order to prevent ill health. However, the influence of lifestyle is sometimes exaggerated and it is only one of many factors that contribute to ill health. I have examined whether it is fair to focus on the lifestyle of individuals, while ignoring other predisposing factors.

Finally, while the notion of distributive justice has been explored in depth, not so much attention has been given to the implications for issues in health care policy such as rationing. As Norman Daniels (1996: 198) states hard questions still remain about 'how to distribute the burdens that result when people 'voluntarily' incur extra risk and swell the costs of health care by doing so.' I have discussed some of the contemporary theories of distributive justice and explored their implications for the allocation of health care resources between individuals.

In this thesis, (Chapter Three), I have reviewed various theories of distributive justice and argued that none of these preclude using lifestyle as one of the criteria in decisions about the allocation of scarce medical resources between individuals. Liberals will

emphasize that people should be allowed to make their own choices about lifestyle, including the choice to indulge in unhealthy and risky activities. However, liberals will also argue that there is no obligation for others to provide health care if people become ill or injured. If people have voluntarily contributed to their need for health care, why should anyone else *have* to help them?

The communitarian may accept more coercive measures and enforcement of legislation in order to promote the health and welfare of the community. There is no suggestion that it would be unfair to give priority to those members of the community who have adopted a healthy lifestyle, if choices have to be made between patients. Indeed, it might be suggested that such a policy would encourage people to avoid known risks and take active steps to maintain a healthy lifestyle, so promoting the welfare of the community generally.

The theories of distributive justice, which were included in the review, do not suggest that it would be unfair in principle to use lifestyle *per se* as one of the criteria in decisions about the allocation of health care resources. Nevertheless, even if considerations of lifestyle are *theoretically* relevant, I have argued that the inclusion of this criterion in these decisions would be unfair *in practice*, except in cases where lifestyle adversely affects clinical outcomes. Doctors and other health care professionals should not make judgements about the lifestyle and former behaviour of their patients for a number of reasons.

Firstly, risk taking is either voluntary or involuntary, as discussed in Chapter Four. If lifestyle choices are involuntary, blame or punishment by denial of treatment is not defensible. However, I have suggested that doctors, or indeed any other health care professionals, are not able to judge whether behaviour is voluntary or involuntary and that it would therefore be unfair to use this criterion.

It is difficult for doctors to judge whether behaviour is voluntary or involuntary because it is not a medical assessment, but rather a character assessment for which they have no special training. In addition, in order to make such judgements doctors would have to make intrusive inquiries which might violate the privacy of their patients. Further, the extent to which lifestyle is a contributory cause to disease and injury varies. It is obvious that a variety of factors will contribute to the need for health care and it follows that judgements apportioning blame are likely to be unreliable. If health care professionals focus exclusively upon individuals and their lifestyle, there is a risk of victim blaming. This is unfair because other people may have contributed to the need for health care. Such an approach may also detract attention from the wider environmental factors which contribute to ill health.

Suppose the lifestyle choices and risk taking are voluntary. Even so, I maintain that the delay or denial of medical treatment is inappropriate. In certain cases, the risk taking may be excused or justified. People may offer excuses to explain and defend their unhealthy behaviour, claiming that they have been unduly influenced by others, or that there are extenuating circumstances to explain their behaviour. Alternatively, people may suggest that their behaviour has been the right thing to do in the circumstances and that the risk has been justified. For example: the young mother smokes because it is one of the pleasures and relaxations that enables her to keep calm and look after her three children in the confines of a small flat. We should be cautious about blaming her for this behaviour. It might be justified by the individual circumstances of the case. It is not always easy to distinguish between excuses and justification and doctors are not well placed to judge.

Even if lifestyle choices are blameworthy, the punishment of delayed or withdrawn medical treatment is disproportionate to risk taking. This 'punishment' seems to be callous and incompatible with the traditional caring role of the doctor whose primary

purpose is to treat patients according to their needs. In addition, using this criterion will undermine the trust which underlies effective communication between doctors and their patients, particularly if treatment is delayed or withdrawn in order to save resources for other or potential patients. Finally, it should be noted that there may be more effective ways to encourage people to improve their lifestyle by education and some forms of persuasion, as discussed in Chapter Five.

The recent emphasis on explicit rationing and on open transparent decision making will allow greater public discussion about which criteria should be used to ration health care. It will be possible to establish certain guidelines for doctors and managers relating to the process of rationing. I propose that these guidelines should include the statement that doctors will *not* allocate health care resources according to the former lifestyle of their patients, except just in as far as it has affected the probable clinical outcomes of treatment. If patients are unwilling to cooperate with future prescribed treatment, then it is justifiable to allocate resources to other patients where the outcomes will be more favourable, and scarce resources can be used more effectively.

The National Institute for Clinical Excellence (NICE) has recently recommended that Xenical (an anti-obesity drug) should only be prescribed to those patients who maintain a calorie controlled diet and exercise programme (Derbyshire 2001). According to these NICE guidelines, patients will have to demonstrate that they have lost weight and met set targets: they must lose at least five per cent of their body weight within three months. If they do not achieve this target the drug will be withdrawn. The allocation of this drug is therefore dependent upon the patient maintaining certain behaviour and demonstrating a commitment to the complete medical treatment.

This assessment of current behaviour is different from judgements about former lifestyle. Firstly, treatment is being provided, but will be discontinued if it is not clinically effective for *whatever* reason, including non-compliance. Secondly, the patient can be informed of the proposed conditions and requirements for ongoing treatment: a contract could be negotiated and agreed between patient and doctor. Since resources are limited in health care, it is justifiable to allocate them to cases where the patient is able and willing to cooperate and the outcomes are beneficial. This is not a decision based upon desert and former behaviour.

The NHS has both a legal and a moral duty to provide reasonable health care for everyone from finances, which are raised by compulsory taxation. If risk takers, as a group, use more than their fair share of the resources, it follows that they may harm those people who have maintained a healthy lifestyle, who may be denied the resources that they need. Individuals do have a corresponding responsibility to attempt to stay healthy so as not to unnecessarily burden their fellow taxpayers. People should be encouraged to maintain a healthy lifestyle by health education, support, and lifestyle drugs on the NHS, if appropriate. Indeed, it is reasonable to do more than provide information, where people may have difficulty acting on their own wishes in the future. Persuasion and warnings are therefore justifiable, particularly for the young and immature, and where behaviour is known to be addictive, or where the information has to compete with advertising or accepted cultural norms.

It is also reasonable to raise extra money for the NHS by placing taxes on products associated with certain known health risks. This already happens in the taxation on tobacco and alcohol and it could be extended to cover some items related to dangerous sports: equipment, permits or events. In this way, people who partake in, or watch dangerous activities will contribute extra funds for the NHS, to cover the potential costs of their behaviour.

If individuals have not maintained a healthy lifestyle (for whatever reason) it is not justifiable to withdraw or delay health care as a 'punishment'. I have argued that it will be difficult to determine who has made an effort to avoid risks, and failed because of circumstances beyond their control, and those who have made minimal or no effort to avoid risks. Unless there is convincing new evidence to demonstrate that health related behaviour is voluntary, it is not justifiable to penalize potential patients, who have taken risks. These people should be treated on the NHS, regardless of their former lifestyle, except in those individual cases where lifestyle has adversely affected the probable clinical effectiveness of treatment.

+ **References**

- Aaron, H.J. and Schwartz, W.B. (1984) *The Painful Prescription: Rationing Hospital Care*, Washington DC: The Bookings Institution.
- Aristotle (1976) *The Ethics of Aristotle The Nicomachean Ethics*, Translated by Thomson J.A.K. Penguin Books: Book III.
- Aristotle (1955) *The Ethics of Aristotle The Nicomachean Ethics*, Translated by Thomson J.A.K. Penguin Books: Book V.
- Austin J.L. (1961) *A Plea for Excuses*, Philosophical Papers, Oxford: Clarendon Press, 122-152.
- Ayer A.J. (1982) 'Freedom and necessity' in Watson G. (Editor) *Free Will*, Oxford Readings in Philosophy: Oxford University Press, 15-23.
- Ballard K. (2000) 'Understanding consumer's views of lifestyle drugs' Electronic responses to 'Education and Debate. Lifestyle medicines' Gilbert D. Walley T. New B. *British Medical Journal*, 321: 1341-1344. Accessed on bmj.com 3/7/01.
- Baumrin B. (1991) 'Putting them out on the ice: curtailing care of the elderly,' *Journal of Applied Philosophy*, 8 (2): 155-160.
- Barendregt J.J. Bonneux L. Van Der Maas P.J. (1997) 'The health care costs of smoking,' *The New England Journal of Medicine*, 337 (15): 1052-1057.
- Barry B. (1995) 'Spherical justice and global injustice' in Miller D. Walzer M. (editors) *Pluralism, Justice, and Equality*, Oxford: Oxford University Press.
- Battin M.P. (1987) 'Age rationing and the just distribution of health care: is there a duty to die?' *Ethics* (97): 317-340.
- Beauchamp D.E. (1983) 'Public health as social justice' in Arras J. Hunt R. (editors) *Ethical Issues in Modern Medicine*, Mayfield Publishing Company: 516-527.
- Beauchamp T.L. Childress J.C. (1989) *Principles of Biomedical Ethics*, Third edition, New York: Oxford University Press.
- Beaumont P. Douglas E. (1995) 'Mother of all mountains, father of all obsessions,' *The Observer*, August 20: 10.
- Beeken S. Waterston T. (1992) 'Health service support of breast feeding - are we practicing what we preach?' *British Medical Journal*, 305: 285-7.

- Bell D. (1993) *Communitarianism and its Critics*, Oxford: Clarendon Press.
- Bellis M. McVeigh J. Thomson R. (1999) 'The national lottery', *Health Service Journal*, June 17: 22-23.
- Benbow S. Jones R. Jolley D. (1999) 'Short rations', *Health Service Journal*, September 16: 26-27.
- Beresford E.B. (1991) 'Uncertainty and the shaping of medical decisions', *Hastings Center Report*, 21: 6-11.
- Bird G.L.A. O'Grady J.G.O. Harvey F.A.H. Calne R.Y. Williams R. (1990) 'Liver transplantation in patients with alcoholic cirrhosis: selection criteria and rates of survival and relapse', *British Medical Journal*, 301: 15-17.
- Blaxter M. (1990) *Health and Lifestyle*, Tavistock: Routledge.
- Blinkhorn A. (1995) 'Health promotion - a behaviour change too far? Comment from the Editor', *Journal of the Institute of Health Education*, 32 (4): 24.
- Bottomley V. (1993) 'Priority setting in the NHS' in Smith R. (editor) *Rationing in Action*, British Medical Journal Publishing Group.
- Bottomley V. (1993), in Department of Health, *The Health of the Nation. One Year On. A Report on the Progress of the Health of the Nation*, Department of Health.
- Bottomley V. (1994) 'Letters. Rationing in action', *British Medical Journal*, 308: 338.
- Bowling A. (1999) 'Ageism in cardiology', *British Medical Journal*, 319: 1353-1355.
- British Heart Foundation (2001) Series of ITV advertisements, February.
- British Medical Association (1993) *The Boxing Debate*, London: British Medical Association.
- British Medical Association (1995) *Rationing Revisited: A Discussion Paper*, Health Policy and Economic Research Unit, Discussion Paper 4, London: British Medical Association.
- British Medical Association (2001) *Healthcare Funding Review*, Health Policy and Economic Research Unit, (Bogle I. Chairman), London: British Medical Association.
- Britton J. (2000) 'Nicotine replacement can be obtained on prescription', *British Medical Journal*, 321: 379-379.

- Brody B. (1992) 'Ethical reflections on international health care expenditures' in Matthews C. Menlowe M. (editors) *Philosophy and Health Care*, Averbury.
- Broome J. (1988) 'Good, Fairness and QALYs' in Bell J.M. Mendus S. (editors) *Philosophy and Medical Welfare*, Cambridge: Cambridge University Press.
- Buchanan A.E. (1989) 'Assessing the Communitarian critique of liberalism', *Ethics*, July: 852-882.
- Bunting M. (1994) 'Backing for dentist who refused to treat children', *The Guardian*, June 28: 3.
- Butler J. (1999) *The Ethics of Health Care Rationing Principles and Practices*, London: Cassell.
- Callahan D. (1987) *Setting Limits: Medical Goals in an Aging Society*, New York: Simon and Schuster.
- Callahan D. (1987) 'Terminating treatment: Age as a standard', *Hastings Center Report*, October/ November: 21-25.
- Callahan D. (1993) 'Response to Roger W. Hunt', *Journal of Medical Ethics*, 19: 24-27.
- Calman K. (1990) 'Foreword' in Downie R.S. Fyfe C. Tannahill A. *Health Promotion Models and Values*, Oxford: Oxford Medical Publications.
- Calman K.C. (1994) 'The ethics of allocation of scarce health care resources: a view from the centre', *Journal of Medical Ethics*, 20: 71-74.
- Campbell A.V. (1993) 'The ethics of health education' in Wilson-Barnett J. Macleod Clark J. (editors) *Research in Health Promotion and Nursing*, Macmillan.
- Chaffer D. (1997) 'Baby friendly initiative: a cause for concern?' *British Journal of Midwifery*, 5 (2): 73-74.
- Chinitz D. Shalev C. Galai N. Israeli A. (1998) 'Israel's basic basket of health services: the importance of being explicitly implicit', *British Medical Journal*, 317: 1005-1007.
- Coast J. 'The case against', *British Medical Journal*, 314: 1118-22.
- Cohen C. Benjamin M. (1991) 'Alcoholics and liver transplantation', *Journal of American Medical Association*, 265: 1299-1301.
- Cochrane M. Ham C. Heginbotham C. Smith R. (1991) 'Rationing: at the cutting edge' *British Medical Journal*, 303: 1039-42.

- Coker R. (1999) 'Public health, civil liberties, and tuberculosis', *British Medical Journal*, 318: 1434-1435.
- Coote A. (1993) 'Public Participation in Decisions about Health Care', *Critical Public Health*, 4 (1): 36-48.
- Coulter A. Ham C. (Editors), (2000) *The Global Challenge of Health Care Rationing*, Buckingham: Open University Press.
- Cudd A.E. (1997) 'Taking drugs seriously: Liberal paternalism and the rationality of references' in LaFollette H. (editor) *Ethics in Practice An Anthology*, Blackwell Philosophy Anthologies, Blackwell Publishers: 309-319.
- Daniels N. (1981) 'Health-care needs and distributive justice', *Philosophy and Public Affairs*, 10 (2): 146-179.
- Daniels N. (1983) 'A reply to some stern criticisms and a remark on health care rights', *The Journal of Medicine and Philosophy*, 8: 363-371.
- Daniels N. (1985) *Just Health Care*, Cambridge: Cambridge University Press.
- Daniels N. (1988) *Am I My Parents' Keeper? An Essay on Justice between the Young and the Old*, Oxford: Oxford University Press.
- Daniels N. (1996) *Justice and Justification Reflective Equilibrium in Theory and Practice*, Cambridge: Cambridge University Press.
- Daniels N. Sabin J. (1997) 'Limits to health care: fair procedures, democratic deliberation, and the legitimacy problem for insurers', *Philosophy and Public Affairs*, 26: 303-350.
- Daniels N. (2000) 'Editorial accountability for reasonableness', *British Medical Journal*, 321: 1300-1301.
- Dawson J. (1994) 'Refusing to treat smokers: why this is untenable', *British Journal of General Practice*, 44 (387): 435-436.
- Delingpole J. (1997) 'Excess, drugs and rock ' n' roll', *The Daily Telegraph*, February 3: 17
- Department of Health (1991) *The Patient's Charter*, Department of Health C1000.
- Department of Health (1992) *The Health of the Nation A strategy for Health in England*, London: HMSO.

Department of Health (1993) *The Health of the Nation One year On... A Report on the Progress of the Health of the Nation*, London: HMSO.

Department of Health (1995) *Variations in Health. What can the Department of Health and the NHS do?* London: HMSO.

Department of Health (1997-98) *The New NHS: Modern. Dependable*, London: The Stationery Office: Cm 3807.

Department of Health (1997-1998) *Our Healthier Nation. A Contract of Health*, London: The Stationery Office: Cm 3852.

Department of Health (1999) *Getting Patients Treated: the Waiting List Action Team Handbook*, Department of Health.

Department of Health (1999) *Saving Lives: Our Healthier Nation*, London: The Stationery Office: Cm 4386.

Department of Health (2000) *National Service Framework for Coronary Heart Disease. Modern Standards and Service Models*, London: Department of Health.

Department of Health (2000) *The NHS Plan: A Plan for Investment, A Plan for Reform*, London: Department of Health: Cm. 4818-I.

Department of Health (1994) *Virginia Bottomley Spells out Policy on NHS Treatment for Elderly People*, Press Release 94/182: 15 April.

Derbyshire D. (2001) 'Anti-obesity drug 'should be available on NHS'', *The Daily Telegraph*, March 10: 14.

Dines A. Cribb A. (1993) *Health Promotion Concepts and Practice*, Blackwell Scientific Publications: 3-19.

Dinsdale P. (1996) 'Prime and Prejudice', *Health Service Journal*, July 18: 32-33.

Dixon J. Gilbert Welch H. (1991) 'Priority setting: Lessons from Oregon', *The Lancet*, 337: 891-894.

Dobson R. (2001) 'Report urges more honest approach to rationing', *British Medical Journal*, 322: 316.

Dolan P. Cookson R. Ferguson B. (1999) 'Effect of discussion and deliberation on the public's views of priority setting in health care: focus group study', *British Medical Journal*, 318: 916-919.

- Doll R. Peto R. Wheatley K. Gray R. Sutherland I. (1994) 'Mortality in relation to smoking: 40 years' observations on male British doctors', *British Medical Journal*, 309: 901-911.
- Donaldson C. (1993) 'Economics of priority setting: let's ration rationally!' *Rationing in Action*, British Medical Journal Publishing Group: 75-84.
- Donnelly L. (1999) 'Schizophrenia patients face denial of new drug treatments', *Health Service Journal*, October 21: 8.
- Doyal L. (1995) 'Needs, rights and equity: moral quality in healthcare rationing', *Quality in Health Care*, 4: 273-283.
- Doyal L. (1997) 'The rationing debate. Rationing within the NHS should be explicit. The case for', *British Medical Journal*, 314: 1114-8.
- Downie R. Fyfe C. Tannahill A. (1990) *Health Promotion: Models and Values*, Oxford: Oxford University Press.
- Dresser R. 'Long-Term (1995) Contraceptives in the Criminal Justice System. Special Supplement', *Hastings Center Report* 25, (1): S15-S18.
- Dubos R. (1968) *Man, Medicine and Environment*, London: Pall Mall Press.
- Dworkin G. (1981) 'Taking risks, assessing responsibility', *The Hastings Center Report*, 11 (5): 26-31.
- Dyer C. (1987) 'Going to law to get treatment', *British Medical Journal*, 295: 1554.
- Dyer C. (1997) 'Ruling on interferon beta will hit all health authorities', *British Medical Journal*, 315: 143-148.
- Edwards S.D. (1996) *Nursing Ethics A Principle-Based Approach*, Basingstoke: Macmillan.
- Emson H.E. (1992) 'Rights, duties and responsibilities in health care', *Journal of Applied Philosophy*, 9 (1): 3-11.
- Entwistle V.A. Watt I.S. Bradbury R. Pehl L.J. (1996) 'Media coverage of the Child B case', *British Medical Journal*, 312: 1587-1591.
- Feinberg J. (1970) *Doing and Deserving. Essays in the Theory of Responsibility*, Princeton, New Jersey: Princeton University Press.
- Fishkin J. S. (1982) *The Limits of Obligation*, Yale University Press.

- Fox R.C. Swazey J.P. (1978) 'Ernie Crowfeather' in *The Courage to Fail. A Social View of Organ Transplants and Dialysis*, Second edition, Revised, Chicago / London: The University of Chicago Press, 266-301.
- Gilbert D. Walley T. New B. (2000) 'Education and Debate. Lifestyle medicines', *British Medical Journal*, 321: 1341-1344.
- Giesen D. (1995) 'A right to health care? A comparative perspective' in Grubb A. Mehlman M.J. (editors) *Justice and Health Care: Comparative Perspectives*, Chicester: John Wiley and Sons, 287-304.
- Gillon R. (1985) *Philosophical Medical Ethics*, John Wiley and Sons.
- Gillon R. (1995) 'On giving preference to prior volunteers when allocating organs for transplantation', *Journal of Medical Ethics*, (21): 195-196.
- Glannon W. (1998) 'Responsibility, alcoholism, and liver transplantation', *Journal of Medicine and Philosophy*, 23: 31-49.
- Glover J. (1977) *Causing Death and Saving Lives*, Penguin Books.
- Glover J. (1970) *Responsibility*, London: Routledge and Kegan Paul.
- Goode E. (1997) 'Between politics and reason. The drug legalization debate', *Contemporary Social Issues*, St. Martin's Press: 27.
- Goodin R.E. (1989) 'The ethics of smoking', *Ethics*, April: 547-624.
- Goodwin R.E. (1997) 'Permissible paternalism: Saving smokers from themselves' in LaFollette H. (editor) *Ethics in Practice. An Anthology*, Blackwell Philosophy Anthologies, Blackwell Publishers.
- Government Committee on Choices in Health Care, The Netherlands (1992) *Choices in Health Care. The Dunning Report*.
- Graham G. (1992) 'Drugs, freedom and harm. Should heroin and cocaine be legalised?' *Cogito*: Spring, 28-35.
- Graham G. (1988) *Contemporary Social Philosophy*, Oxford: Basil Blackwell.
- Green L. (1987) 'Letter to the editor', *Health Education Quarterly*, 14 (1): 4.
- Grimley Evans J. (1993) 'Health care rationing and elderly people' in: Tunbridge M. (editor) *Rationing of Health Care in Medicine*, Royal College of Physicians of London, 43-53.

- Grimley Evans J. (1997) 'Rationing health care by age. The case against' in New B. (editor) *Rationing, Talk and Action in Health Care*, London: Kings Fund and BMJ Publishing Group, 115-121.
- Gutmann A. (1985) 'Communitarian critics of Liberalism', *Philosophy and Public Affairs*, Summer 1985: 308-322.
- Gutmann A. (1995) 'Justice across the spheres' in Miller D. Walzer M. (editors) *Pluralism, Justice, and Equality* Oxford: Oxford University Press.
- Gutmann A. Thompson D. (1996) *Democracy and Disagreement*, Cambridge, Massachusetts: The Belknap Press of Harvard University Press.
- Haavi Morreim E. (1995) 'Lifestyles of the Risky and Infamous. From managed care to managed lives', *Hastings Center Report*, 25 (1): 5-12.
- Hall C. (1993) 'Doctors tackle lifestyle dilemmas', *The Independent*, November 8: 4.
- Ham C. (1981) *Policy-making in the National Health Services. A Case Study of the Leeds Regional Hospital Board*, Macmillan Press Ltd.
- Ham C. (1992) *Health Policy in Britain. The Politics and Organisation of the National Health Service*, Third edition, Macmillan.
- Ham C. (1995) 'Health care rationing. The British approach seems likely to be based on guidelines', *British Medical Journal*, 310: 1483-1484.
- Ham C. McIver S. (2000) *Contested Decisions. Priority Setting in the NHS*, London: Kings Fund.
- Ham C. Pickard S. (1998) 'Tragic Choices in Health Care. The case of Child B', London: King's Fund.
- Hanratty B. Lawlor D.A. Robinson M.B. Sapsford R.J. Greenwood D. Hall A. (2000) 'Sex differences in risk factors, treatment and mortality after acute myocardial infarction: an observational study', *Journal of Epidemiology and Community Health*, 54: 912-916.
- Harris J. (1985) *The Value of Life. An Introduction to Medical Ethics*, London: Routledge.
- Harris J. (1987- 8) 'EQALYTY' in Byrne P. (editor) *Health Rights and Resources: Kings College Studies*, King Edward's Hospital Fund for London, 100-127.
- Harris J. (1987) 'QALYfying the value of life', *Journal of Medical Ethics*, 13: 117-122.

- Harris J. (1988) 'More and better justice' in Bell J.M. Mendus S. (editors) *Philosophy and Medical Welfare*, Cambridge: Cambridge University Press.
- Harris J. (1995) 'Double jeopardy and the veil of ignorance – a reply', *Journal of Medical Ethics*, 21: 151-157.
- Harris J. (1996) 'What is the good of health care?' *Bioethics*, 10 (4): 269-291.
- Harrison S. (1995) 'A policy agenda for health care rationing' in Maxwell, R. J. (editor) *Rationing Health Care*, *British Medical Bulletin*, 51 (4): 885-899.
- Haydock A. (1992) 'QALYs - A threat to our quality of life?' *Journal of Applied Philosophy*, 9 (2): 183-188.
- Hayek F.A. (1991) 'Freedom and coercion' in Miller D. (editor) *Liberty* Oxford: Oxford University Press.
- Hayek F.A. (1992) 'Liberty, equality, and merit' in Sterba J.P. *Justice. Alternative Political Perspectives*, Second edition, Wadsworth Publishing Company, 27-40.
- Health Education Authority (1993) *Fact File, Smoking and Young People*, HEA.
- Hellman S. (1997) 'The patient and the public good' in LaFollette (editor) *Ethics in Practice. An Anthology*, Blackwell, 436-440.
- Higgs R. (1985) 'On telling patients the truth' in Lockwood M. (editor) *Moral Dilemmas in Modern Medicine*, Oxford: Oxford University Press.
- Higgs R. (1993) 'Human frailty should not be penalised' *British Medical Journal*, 306: 1049-1050.
- Holm S. (1998) 'Goodbye to the simple solutions: the second phase of priority setting in health care', *British Medical Journal*, 317: 1000-1007.
- Honderich T. (1969) *Punishment the Supposed Justifications*, Hutchinson of London.
- Honderich T. (1993) *How Free are You? The Determinism Problem*, Oxford: Oxford University Press.
- Honigsbaum F. (1992) 'Who shall live? Who shall die? Oregon's health financing proposals', London: *King's Fund College Papers*.
- Hope T. Hicks N. Reynolds D.J.M. Crisp R. Griffiths S. (1998) 'Rationing and the Health Authority', *British Medical Journal*, 317: 1067-1069.

- Hope T. Sprigings D. Crisp R. (1993) ' "Not clinically indicated": patients' interests or resource allocation?' *British Medical Journal*, 306: 379-381.
- Hospers J. (1992) 'The Libertarian Manifesto' in Sterba J.P. *Justice. Alternative Political Perspectives*, second edition, Wadsworth Publishing Company, 41-53.
- Hunter D.J. (1997) *Desperately Seeking Solutions. Rationing Health Care*, London and New York: Longman.
- Hunter D.J. (1995) 'Rationing health care: the political perspective' in *British Medical Bulletin*, 51 (4): 876-884.
- Hunt R.G. (1993) 'A critique of using age to ration health care' *Journal of Medical Ethics*, 19: 19-23.
- Human Rights Act 1998, London: The Stationery Office.
<http://www.hmsso.gov.uk/acts/acts1998/19980042.htm>
- Hume D. (1975) *An Enquiry Concerning Human Understanding*, Selby-Brigge L.A. (editor), 3rd edition, Oxford: Clarendon Press, Section VIII.
- Husak D. N. (1994) 'Is drunk driving a serious offence?' *Philosophy and Public Affairs*, 23 (1): 52-73.
- Iliffe S. (1993) 'Who killed Harry Ephlick?' *Health Matters*, Issue 15, Autumn, 5.
- Jackson J. (1991) 'Telling the truth', *Journal of Medical Ethics*, 17: 5-9.
- Jaggar A.M. (1992) 'Socialist feminism and human nature' in Sterba J.P. *Justice. Alternative Political Perspectives*, Second edition, Wadsworth Publishing Company, 304-315.
- Jarvis R. (1995) 'Join the club: a modest proposal to increase availability of donor organs', *Journal of Medical Ethics*, 21: 199-204.
- Jones S. (1996) 'Need to improve breastfeeding rates', *Nursing Standard*, 10 (43) July 17: 10.
- Kenny A. (1978) *Freewill and Responsibility*, London: Routledge and Kegan Paul.
- Khaw K. (1999) 'How many, how old, how soon?' *British Medical Journal*, 319: 1350-1352.
- Klein R. (1989) *The Politics of the National Health Service*, Second edition, Longman.

- Klein R. Day P. Redmayne S. (1995) 'Rationing in the NHS: the dance of the seven veils – in reverse' in Maxwell, R.J. (editor) *Rationing Health Care, British Medical Bulletin*, 51 (4): 769-780.
- Klein R. Day P. Redmayne S. (1996) *Managing Scarcity. Priority Setting and Rationing in the National Health Service*, Buckingham: Open University Press.
- Klein R. (1997) 'The case against', *British Medical Journal*, 314: 506-509.
- Klein R. (1998) 'Puzzling out priorities', *British Medical Journal*, 317: 959- 960.
- Kmietowicz Z. (2000) 'Doctors told to treat nicotine addiction as a disease', *British Medical Journal*, 320: 397.
- Kymlicka W. (1990) *Contemporary Political Philosophy. An Introduction*, Oxford: Clarendon Press.
- Le Grand J. (1991) *Equity and Choice: An Essay in Economics and Applied Philosophy*, Harper Collins Academic.
- Leichter H. (1981) 'Public policy and the British experience', *The Hastings Center Report*, October, 32-39.
- Lenaghan J. (1996) *Rationing and Rights in Health Care*, Institute for Public Policy Research.
- Lenaghan J. (1997) 'Central government should have a greater role in rationing decisions', *British Medical Journal*, 314: 967-970.
- Lewis P.A. Charny M. (1989) 'Which of two individuals do you treat when only their ages are different and you can't treat both?' *Journal of Medical Ethics*, 15: 28-32.
- Lockwood M. (1981) 'Rights', *Journal of Medical Ethics*, 7: 150-152.
- Lockwood M (1988) 'Quality of life and resource allocation.' in Bell J.M. Mendus S. (editors) *Philosophy and Medical Welfare*, Cambridge University Press.
- Lockwood M. (1994) 'Identity matters' in Fulford K.W.M. Gillett G.R. Soskice J.M. (editors) *Medicine and Moral Reasoning*, Cambridge University Press, 60-74.
- Lucas J.R. (1993) *Responsibility*, Oxford: Clarendon Press, 13-32.
- Lucey M.R. Merion R. M. Henley K.S. Campbell D.A. Turcotte J.G. Nostrant T.T. Blow F.C. Beresford T.P. (1992) 'Selection for and outcome of liver transplantation in alcoholic liver disease', *Gastroenterology*, 102: 1736-1741.

- Lutter C. (editor) (1990) 'Towards Global Breastfeeding' *Institute for Reproductive Health (Institute Issues Report)*, Washington: Georgetown University.
- Machan T. (1992) 'The Nonexistence of Basic Welfare Rights' in Sterba J.P. (editor) *Justice. Alternative Political Perspectives*, second edition, Wadsworth Publishing Company, 64-72.
- Machan T.R. (1993) 'Applied ethics and free will: some untoward results of independence', *Journal of Applied Philosophy*, 10 (1): 59-72.
- MacIntyre A. (1984) *After Virtue. A Study in Moral Theory*, second edition, University of Notre Dame Press.
- MacIntyre A. (1992) 'The Privatization of Good' in Sterba J. P. (editor) *Justice. Alternative Political Perspectives*, second edition, Wadsworth Publishing Company, 239-251.
- Mackie J.L. (1977) *Ethics Inventing Right and Wrong*, Penguin Books.
- Marx K. Engles F. (1992) 'The Socialist Ideal' in Sterba J.P. (editor) *Justice. Alternative Political Perspectives*, second edition, Wadsworth Publishing Company, 75-86.
- Mason J.K. McCall Smith R.A. (1994) *Law and Medical Ethics*, fourth edition, Butterworths.
- Maynard A. (1994) 'Prioritising health care – dreams and reality' in Malek M. (editor) *Setting Priorities in Health Care*, Chichester: John Wiley and Sons.
- Maynard A. (1996) 'Editorial: rationing health care', *British Medical Journal*, 313: 1499.
- Maxwell R.J. (1995) 'Can we do better?' *British Medical Bulletin*, 51 (4): 941-948.
- McLachlan H. V. (1995) 'Smokers, virgins, equity and health care costs', *Journal of Medical Ethics*, 21: 209-213.
- Mechanic D. (1992) 'Professional judgment and the rationing of medical care', *University of Pennsylvania Law Review*, 140 (5): 1713-1754.
- Mechanic D. (1995) 'Dilemmas in rationing health care services: the case for implicit rationing', *British Medical Journal*, 310: 1655-1659.
- Milburn A. (1997) *Newsnight*, BBC 2, December 9.

- Mill J.S. (1912) *On Liberty. Representative Government. The Subjection of Women*, Oxford: Oxford University Press.
- Miller D. Walzer M. (1995) *Pluralism, Justice, and Equality*, Oxford: Oxford University Press.
- Montgomery J. (1997) *Health Care Law*, Oxford: Oxford University Press.
- Moore A. (2001) 'Pound of flesh', *Health Service Journal*, 1 March: 16-17.
- Moss A. Siegler M. (1991) 'Should alcoholics compete equally for liver transplantation?' *Journal of American Medical Association*, 265: 1295-1298.
- Moxham J. (2000) 'Nicotine addiction', *British Medical Journal*, 320: 391-392.
- Murray S.F. (editor) (1996) *Baby Friendly. Mother Friendly*, Mosby.
- National Health Service Act 1977, London: HMSO.
- Nell E. O'Neill O. (1992) 'Justice Under Socialism' in Sterba J.P. (editor) *Justice. Alternative Political Perspectives*, second edition, Wadsworth Publishing Company, 87-97.
- New B. (1996) 'The rationing agenda in the NHS', *British Medical Journal*, 312: 1593-1601.
- New B. Le Grand J. (1996) *Rationing in the NHS. Principles and Pragmatism*, London: King's Fund.
- Newdick C. (1995) *Who Should We Treat? Law, Patients and Resources in the N.H.S.*, Oxford: Clarendon Press.
- Newdick C. (1993) 'Rights to NHS resources after the 1990 Act', *Medical Law Review*, 1: 53 –82.
- Nielson K. (1992) 'Radical Egalitarianism' in Sterba J.P. (editor) *Justice. Alternative Political Perspectives*, second edition, Wadsworth Publishing Company, 98-111.
- NHS Executive (1998) *Breast cancer waiting times – achieving the two-week target*, HSC 1998 / 242.
- NHS Executive (1999) *Clinical Governance. Quality in the New NHS*, Department of Health.
- Nozick R. (1972) 'Coercion' in Laslett P. Runciman W.G. Skinner Q. *Philosophy, Politics and Society*, fourth series, Basil Blackwell, 101-135.

- Nozick R. (1974) *Anarchy, State, and Utopia* Basil Blackwell.
- Oommen T. (2000) 'More about Nicotine' *bmj.com*: 15 Feb.
- Orwell G. (1990) *Nineteen Eighty-four*, Penguin.
- Pallot P. Fletcher D. (1994) 'Dentist to face inquiry over ban on children', *The Daily Telegraph*, June 28: 6.
- Palmer G. Kemp S. (1996) 'Breastfeeding promotion and the role of the professional midwife' in Murray S.F. (editor) *Baby Friendly Mother Friendly* Mosby, 9-10.
- Parfit D. (1986) *Reasons and Persons*, Oxford: Oxford University Press.
- Parsons V. Lock P. (1980) 'Triage and the patient with renal failure', *Journal of Medical Ethics*, 6: 173-176.
- Pelosi A. (2000) 'Editorials. Dilemmas and choices in facing the drugs problem', *British Medical Journal*, 320: 885-886.
- Persaud R. (1995) 'Smokers' rights to health care', *Journal of Medical Ethics*, 21: 281-287.
- Plant R. (1991) *Modern Political Thought*, 'The Claims of Need and Politics', Oxford: Blackwell, 184-220.
- Plato (1974) *The Republic* translated by Lee D., second edition (revised), Penguin Books, Part One (Book Two).
- Pojman L.P. McLeod O. (1999) *What Do We Deserve? A Reader on Justice and Desert*, New York: Oxford University Press.
- Rachels J. (1986) *The End of Life. Euthanasia and Morality*, Oxford: Oxford University Press.
- Rachels J. (1997) 'Punishment and desert' in LaFollette H. (editor) *Ethics in Practice: An Anthology*, Blackwell, 470-179.
- Radford A. (1996) 'Justified changes', *Nursing Standard*, 10 (43): 16.
- Rawles J. (1989) 'Castigating QALYs', *Journal of Medical Ethics*, 15: 143-147.
- Rawls J. (1972) *A Theory of Justice*, Clarendon Press.

- Rawls J. (1982) 'Social unity and primary goods' in Sen A. Williams B. (editors) *Utilitarianism and Beyond*, Cambridge: Cambridge University Press, 159-186.
- Rawls J. (1993) *Political Liberalism*, New York: Columbia University Press.
- Redmayne S. Klein R. (1993) 'Rationing in practice: the case of in vitro fertilisation', *British Medical Journal*, 306: 1521-4.
- Rogers L. (1993) 'Hospitals refuse to operate on heart patients who smoke', *The Sunday Times*, May 23: 1.
- Royal College of Nursing (1997) *Nurses against Tobacco Fact File*, London: Royal College of Nursing.
- Royal College of Physicians of London (1995) *Setting Priorities in the NHS. A Framework for Decision-Making*, London: Royal College of Physicians.
- Royal College of Physicians, Tobacco Advisory Group (2000) *Nicotine Addiction in Britain*, London: Royal College of Physicians of London.
- Royal College of Physicians (1992) *Smoking and the Young*, London: RCP.
- Royal Commission on the National Health Service (1979) *Report, CMND 7615*, HMSO.
- Rundall P. (1996) 'The commercial pressures against baby friendliness' in Murray S.F. (editor) *Baby Friendly Mother Friendly*, Mosby.
- Sabin J.E. (1998) 'Fairness as a problem of love and the heart: a clinician's perspective on priority setting', *British Medical Journal*, 317: 1002-1005.
- Sandel M.J. (1982) *Liberalism and the Limits of Justice*, Cambridge: Cambridge University Press.
- Seedhouse D. (1986) *Health The Foundation for Achievement*, Wiley Medical Publication, John Wiley and Sons.
- Sher G. (1987) *Desert*, Princeton, New Jersey: Princeton University Press.
- Smiley M. (1992) *Moral Responsibility and the Boundaries of Community*, Chicago and London: The University of Chicago Press.
- Sterba J.P. (1992) 'From Liberty to Welfare' in Sterba J.P. (editor) *Justice. Alternative Political Perspectives*, second edition, Wadsworth Publishing Company, 54-63.
- Sterba J.P. (editor) (1992) *Justice. Alternative Political Perspectives*, second edition, Wadsworth Publishing Company.

- Steinbock B. (1995) 'Coercion and long-term contraceptives', Special Supplement, *Hastings Center Report* 25 (1): S19-S22.
- Stoll B.A. (1990) 'Choosing between cancer patients', *Journal of Medical Ethics*, 16: 71-74.
- Strang J. Witton J. Hall W. (2000) 'Improving the quality of the cannabis debate: defining the different domains', *British Medical Journal*, 320: 108-110.
- Swift A. (1995) 'The sociology of complex equality' in Miller D. Walzer M. (editors) *Pluralism, Justice, and Equality*, Oxford: Oxford University Press.
- Sylvester R. (2000) '£10 weekly vouchers plan for mothers who breast-feed', *The Daily Telegraph*, April 25: 1.
- Tannahill A. (1984) 'Health promotion -caring concern', *Journal of Medical Ethics*, 10: 196-198.
- Tones B.K. (1987) 'Health education, PSE and the question of voluntarism', *Journal of the Institute of Health Education*, 25 (2): 41-52.
- Tones K. Tilford S. (1994) *Health Education: Effectiveness, Efficiency and Equity*, second edition, Chapman and Hall.
- Tones K. (1997) 'Health education, behaviour change and the public health' in Detels R. Holland W.W. McEwen J. Omenn G.S. (editors) *Oxford Textbook of Public Health* (3rd edition) Volume 2, The Methods of Public Health, Oxford: Oxford University Press.
- Tonks A. (1992) 'The drug laws: ripe for reform?' *British Medical Journal*, 305 (1): 269.
- Underwood M.J. Bailey J.S. (1993) 'Coronary bypass surgery should not be offered to smokers' *British Medical Journal*, 306: 1047-48.
- Veatch R.M. (1981) *A Theory of Medical Ethics*, New York, 276-281.
- Veatch R.M. (1983) 'Voluntary risks to health: the ethical issues' in Arrás J. Hunt R. *Ethical Issues in Modern Medicine*, Mayfield Publishing Company.
- Walker M. (1997) 'Geographies of responsibility', *Hastings Center Report*, 27 (1): 38-44.
- Walzer M. (1983) *Spheres of Justice*, Basic Books.
- Warburton N. (1998) 'Freedom to box', *Journal of Medical Ethics*, 24: 56-60.
- Ward E.D. (1986) 'Dialysis or death? Doctors should stop covering up for an inadequate health service', *Journal of Medical Ethics*, 12: 63.

- Warnock M. (1978) *Ethics Since 1900*, third edition, Oxford: Oxford University Press, 99.
- Weale A. (editor) (1988) *Cost and Choice in Health Care. The Ethical Dimension*, King Edward's Hospital Fund for London.
- Weale A. (1995) 'The ethics of rationing' in Maxwell R.J. (editor) *British Medical Bulletin*, Rationing Health Care, Churchill Livingstone, 51 (4): 831-841.
- Weale S. (1994) 'Age blow to childless seeking IVF', *The Guardian*, October 18.
- Welch H.D. (1989) 'Health care tickets for the uninsured first class, coach or standby?' *The New England Journal of Medicine*, 321 (18): 1261-1264.
- Whitaker P. (1990) 'Resource allocation: a plea for a touch of realism', *Journal of Medical Ethics*, 16: 129-131.
- Whitfield L. (1999) 'Come in number 35, your time is up', *Health Service Journal*, September 2: 10-11.
- Whitfield L. (1999) 'Ups and downs', *Health Service Journal*, June 10: 14-15.
- Whitehead M. (1987) *The Health Divide: Inequalities in Health in the 1980s*, London: Health Education Council.
- Wiggins D. (1978) 'Claims of Need' in Honderich T. (editor) *Morality and Objectivity*, Routledge and Kegan Paul, 149-202.
- Wikler D.I. (1978) 'Persuasion and coercion for health. Ethical issues in government efforts to change life-styles', *Millbank Memorial Fund Quarterly / Health and Society*, 56 (3): 303-317.
- Wilkinson S. (1999) 'Smokers' rights to health care: Why the 'restoration argument' is a moralising wolf in a liberal sheep's clothing', *Journal of Applied Philosophy*, 16 (3): 255-269.
- Williams B. (1973) 'The idea of equality' in *Problems of the Self*, Cambridge: Cambridge University Press, Chapter 14.
- Williams K. (1996) 'Breast or bottle - a woman's right to choose', *Nursing Standard*, 10 (43): 14-15.
- Williams A. (1992) 'Cost-effectiveness analysis: is it ethical?' *Journal of Medical Ethics*, 18: 7-11.

- Williams A. (1988) 'Ethics and efficiency in the provision of health care' in Bell J.M. Mendus S. (editors) *Philosophy and Medical Welfare*, Cambridge: Cambridge University Press, 111-126.
- Williams A (1985) 'The value of QALYs', *Health and Social Service Journal*, July 3.
- Wilson J.Q. (1997) 'Against the legalization of drugs' in LaFollette H. (editor) *Ethics in Practice An Anthology*, Blackwell Philosophy Anthologies, Blackwell Publishers, 303-308.
- Wilson J. (1986) 'Patients' wants versus patients' interests', *Journal of Medical Ethics*, 12: 127-130.
- Wing A.J. (1984) 'Why don't the British treat more patients with kidney failure?' *British Medical Journal*, 287: 1157-8.
- Winslow G.R. (1982) *Triage and Justice*, Berkeley: University of California Press.
- World Health Organisation (1986) *Ottawa Charter for Health Promotion*, Geneva: World Health Organisation.
- Young J. Robinson J. Dickinson E. (1998) 'Rehabilitation for older people', *British Medical Journal*, 316: 1108-1109.