

Responsibility, accountability, and
distributive justice : a case for
discontinuing universally subsidised
healthcare in New Zealand.

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0.0 Introduction

Technology has advanced in leaps and bounds over the last few decades, and countries with universal healthcare policies are now beginning to struggle. Health care is more expensive and, with growing populations, governments cannot continue to provide the same level of healthcare as they have in the past. Many have tried to suggest a system for allocating medical resources, which not only preserves the resources, but also ensures they are distributed fairly.

In the field of bioethics, there has been much debate regarding whether or not those, who are morally responsible in some way for the development of their illness, should still be able to access medical resources. I will suggest within this thesis that those who are morally responsible for their injuries or illnesses no longer have a *right* to subsidised healthcare, provided by the State. Instead, those individuals should cover at least some, if not all, the costs of their medical treatment. I will also propose that when in direct competition for resources, that is, organ transplants, those who were instrumental in the cause of their sickness should receive reduced entitlements.

The proposal is particularly relevant considering that on 11 October 2009, TVNZ 3 News reported that ACC, New Zealand's Accident Compensation Corporation, had made the 'biggest corporate loss in New Zealand history.' They were over twelve billion dollars in debt with no foreseeable way to resolve the situation.¹ ACC is just one of the corporations responsible for ensuring that all New

¹ <http://www.3news.co.nz/ACC-bail-out-could-cost-taxpayer---Smith-/tabid/370/articleID/124915/cat/772/Default.aspx>. Date accessed 7 November, 2009.

Zealanders receive subsidised healthcare. The two other agencies are local District Health Boards, and PHARMAC, who are responsible for funding pharmaceuticals.

The current level of subsidies cannot continue, and ACC are cutting services and raising levies. Motorcyclists were one group targeted by levy increases. In 2007, there were over one thousand motorcyclists injured on New Zealand's roads.² Motorcyclists, angry about the increases to levies, staged several protests. The motorcyclists believed that to raise their levies was unfair; this thesis attempts to prove that it is.

In this thesis, I plan to show that health resources should be distributed based on moral merit. This ensures that those with preventable, self-caused, sickness do not unfairly deplete health resources. These individuals are a burden on healthcare resources so, in order for government funding to continue to be a sustainable practice, something must be done to 'block the drain.'

Health resources are distributed justly when based on John Roemer's 'Equality of Opportunity' theory.³ After the initial distribution, additional resources are allocated based on merit. Thus, everyone has a fair share of medical resources. Those that consume more than their allocated fair share, due to moral responsibility, need to restore the resources they have unfairly consumed. To achieve this goal, the 'guilty' party will be required to fund some, if not all, the costs of their medical treatment.

² http://www.transport.govt.nz/research/Documents/Motorcycle-Crash_Factsheet.pdf. Date accessed 7 November, 2009.

³ Roemer, John E. (1998) *Equality of Opportunity* Harvard University Press : United States of America

This thesis hinges on several assumptions: first, that moral responsibility can be determined. The first chapter is devoted to a brief examination of this topic. After examining the theories of Aristotle, Harry Frankfurt, Peter Strawson and Susan Dwyer, it is concluded that Walter Glannon provides the most pertinent account of moral responsibility.

The second assumption is that there is no right to healthcare. A positive right to healthcare would indicate that, regardless of how sickness developed, receiving medical treatment is a matter of right. The second chapter discusses this supposed right to healthcare. I aim to determine whether the right to health care is a positive absolute, or positive *prima facie*. A *prima facie* right is one that can be ‘trumped’ when in competition with other rights. In this chapter, I will also determine whether the right to health care can be overridden in certain circumstances.

The third assumption is that, if such a policy is paternalistic, paternalism is justifiable. The third chapter outlines some objections to the theory and features a discussion of paternalism. Using the neutrality constraint shows that paternalism is justified.

After discussing the main assumptions, the thesis focuses on justifying the proposal. One of the main arguments for allocation of resources based on merit is the ‘restoration argument.’ This argument suggests that it is morally permissible to require those who consume more than their fair share of resources to restore the resource pool to its previous state. Stephen Wilkinson attacks the ‘restoration argument’ by using what he calls the ‘reverse restoration argument.’ Chapter Four is

not only devoted to outlining the ‘restoration argument’ but also a reply to Wilkinson’s critique.

Research into this area has identified one particular point of interest: addicts. Intuitively, addicts are morally responsible for their conditions, as they make a choice to indulge in a known addictive substance. Research into the area of addiction suggests that potential addicts are more likely to underestimate their susceptibility to addiction, and therefore become addicted. Addiction, and the effect on it has on moral responsibility, is discussed in chapter five.

The final chapter acknowledges the remaining practical issues, and of particular interest is how moral responsibility could be determined fairly and consistently. The first section discusses the problem of genes and their relationship to moral responsibility. Next, I present Roemer’s ‘Equality of Opportunity’ theory as the most just way of distributing resources. I also outline my ‘Responsibility Continuum’; a tool designed to designate moral responsibility. The final discussion includes some closing recommendations.

I have reached my conclusion, that people should be held morally accountable for their health states, by researching the various areas related to the topic. Unfortunately, space constraints have required me to limit my analysis of areas, such as moral responsibility, rights and duties, and addiction, to only a brief examination. There is certainly more scope for discussion on this topic.

Saving healthcare dollars is simply a case of holding individuals accountable for their actions. To do so empowers the population to take control of their health states. Everyone must scrutinise their lifestyle choices, and choose between the vice, or subsidised medical treatment. I believe that reasonable people will choose the latter, and sacrifice these unhealthy behaviours. As a result, problems such as smoking, obesity, and self-caused sicknesses will no longer be a problem for the healthcare system.

Chapter One: Whose fault? Moral responsibly theories

'Responsibility for health is a matter of degree, as is the strength of claims to be treated for a disease.' – Walter Glannon.⁴

1.0 Introduction

Responsibility attribution is problematic, as it can be influenced by individual feelings. One parent may hold their child responsible for certain actions that another would not. The example of Roger Smith, which appears frequently in responsibility literature, shows just how subjective these judgments can be.⁵ Emotions, such as empathy, and the amount of information known about a case can affect responsibility attribution.

Smith and his brother came across two teenagers in a park, who were eating burgers, and they decided to kill them for the meal. After committing the murders, Smith was overhead laughing and joking about the crime. Once eating the teenager's meal, the two men decided to pose as police officers, and inform the dead teen's parents of their son's deaths.⁶

⁴ Glannon, Walter (1998) 'Alcoholism and Liver Transplantation' *Journal of Medicine and Philosophy* Vol. 23, Number 1, Pg. 33

⁵ Vogel, Lawrence (1993) 'Understanding and Blaming: Problems in the Attribution of Moral Responsibility' *Philosophy and Phenomenological Research* Vol. 53, Number 1, Pg. 134 C.f. Cartwright, Will (2006) 'Reasons and Selves: Two Accounts of Responsibility in Theory and Practice' *Philosophy, Psychiatry & Psychology*, Vol. 13, Number 2, June pp 143-155. Note: I have changed the name from John Harris to Roger Smith. This is so the murderer is not confused with the philosopher of the same name, whose work I cite in later sections.

⁶ Vogel, Lawrence (1993), Pg. 134

Roger Smith's actions are abhorrent. The two men murdered the teenagers in cold blood over something trivial, a takeaway meal. The crime is horrifying in itself, but is made worse by the way Smith and his brother revel in the misery they have caused. It is instinctive to attribute moral responsibility to Smith and his brother for the crimes. They were lucid, free from any coercive influences, and clearly felt no remorse.

However, when hearing more information regarding Smith's upbringing and background, these responsibility attributions no longer seem so simple. His mother and father physically and verbally abused Roger. Due to a learning disability, he was bullied at school. At fourteen, he was placed in juvenile detention for stealing a car. Whilst in prison he was raped repeatedly.⁷ All these factors no doubt played a role in shaping Smith's actions on the day of the murders.

Initially, it seems that Smith is morally responsible for the crime, but the example shows that the amount of information affects responsibility. This is because social, cultural, economic, educational and other similar factors all play a role in the formation of our characters. Other aspects, such as empathy, affect the judgment of those assigning moral culpability. Responsibility attribution is not black and white, and many authors have struggled to account for it.

In this chapter, I will look at some of the responsibility theories put forward by authors such as Aristotle, Harry Frankfurt, Peter Stawson and Susan Dwyer, and Walter Glannon. Through discussion of these theories, I will highlight the relevant

⁷ Vogel, Lawrence,(1993), Pg. 134

aspects of moral responsibility for the purposes of this project, which include when an agent is or is not morally responsible for an action. I will particularly focus on the issues of acts of omission, moral development, and causal responsibility for health states.

1.1 Aristotle and Moral Responsibility

Aristotle was one of the first authors to analyse moral responsibility. His ideas, in many ways, both coincide with and radically differ from modern accounts. I have focussed my discussion of Aristotle's moral responsibility theory to Book Three of the *Nicomachean Ethics*, but he also deals with moral responsibility in the *Eudemian Ethics*. Of particular interest is Aristotle's discussion of voluntary and involuntary actions.

1.1.1 Aristotle on Voluntary Actions

Aristotle believes that voluntary actions are those for which agents can fairly receive praise or blame.

'Virtue, then, is about feelings and actions. These receive praise or blame when they are voluntary, but pardon, sometimes even pity, when they are involuntary. Hence, presumably, in examining virtue we must define the voluntary and the involuntary.'⁸

⁸ Cohen, Curd and Reeve (2005) *Readings in Ancient Greek Philosophy: From Thales to Aristotle* 3rd Edition : United States of America Pg. 852 § 1109b L 30-35

Aristotle has established that a moral action is one which the perpetrator can receive praise or blame for. Therefore, when one is morally responsible one is the recipient of praise or blame. This echoes a sentiment expressed by Peter Strawson who believed that an agent was morally responsible for an action insofar that they are an *appropriate candidate* for the reactive attitudes associated with moral responsibility.⁹ If they are not the appropriate candidate, then they are not morally responsible for the action.

In Book Three of the *Nicomachean Ethics*, Aristotle attempts to define involuntary and voluntary actions. An action is voluntary when the ‘moving principle’ comes from the agent, which instigates the action. For Aristotle, this means the action issues from the agent’s own bodily movement. Awareness of the action is also required for the agent to be acting voluntarily. Therefore, if an agent knocks over a vase accidentally, they are not responsible. The movement came from their body, but they were not aware that they were performing that action. Agent’s who are unaware of their actions are not morally responsible, even if the action originates with them.

Aristotle notes that involuntary actions are performed under compulsion and are external to the agent, that is, caused by something outside the agent.

‘What comes about by force or because of ignorance seems to be involuntary. What is forced has an external origin, the sort of origin in which the agent or victim contributes nothing.’¹⁰

⁹ Fischer, J. M & Ravizza, M (1998) *Responsibility and Control: A Theory of Moral Responsibility* United States of America : Cambridge University Press Pg. 6

¹⁰ Cohen, Curd and Reeve (2005), Pg. 853 §1110a L 1-3

This statement may appear to apply to situations of coercion, but when Aristotle states that ‘the agent or victim contributes nothing’ he literally means that the agent should have committed no physical action, as Aristotle believes that for an agent to be responsible the action must be associated with the agent’s own bodily movement. This raises a question over whether Aristotle would hold an agent morally responsible for an act of omission. Acts of Omission are actions that occur when the agent has deliberately chosen not to act (discussed § 1.2).

Aristotle defines involuntary actions further in the section.

‘Everything caused by ignorance is non-voluntary, but what is involuntary also causes pain and regret... the agent who now regrets his action seems to be unwilling, while an agent with no regrets may be called non-willing...’¹¹

According to Aristotle, any agent who performs an action in ignorance, and feels subsequent pain and regret has done so involuntarily. This is distinct from those who may perform an action in ignorance, but upon learning the true nature of their action, do not feel pain, but are instead happy. An involuntary action occurs when the agent has acted without being fully aware of all relevant factors. Aristotle identifies these six factors, or ‘particulars’ as he calls them. If an agent is ignorant of any of these factors the action in question is involuntary.

¹¹ Cohen, Curd and Reeve (2005), Pg. 854 § 1110b L 18-24

- 1) The agent can be ignorant of who is committing action. Aristotle notes that this seems unlikely to occur unless the agent is mad. A modern example is an individual who suffers from multiple personality disorder.
- 2) The agent may not be aware of what he is doing, that is, doing something without thinking.
- 3) An agent can be ignorant about what he is doing, or to whom he is doing it. Aristotle uses the example of Merope, who believed his son to be an enemy. Another example, from Greek mythology, is Oedipus who killed his father, committing patricide, without knowing the man he was killing was his father.
- 4) The agent may not be aware of what he is doing with the instrument of his action. For example; smoking a cannabis joint believing it was a cigarette.
- 5) The agent may not be aware of the results of his action, or he may believe his actions will have a different outcome. This is probably the most pertinent to healthcare as it is feasible that agents will act in unhealthy ways without realising the potential, harmful consequences of their actions.
- 6) The manner in which the agent performs the action. For example, gently or hard, sometimes children try to play with babies the same way they would play with their peers, not realising that the baby needs to be treated more gently.

If the agent is ignorant of the above particulars and feels pain and regret after performing the action, then it is involuntarily. This means that, according to Aristotle, an agent should not be held morally responsible (or perhaps accountable) for the action. I believe this raises a question over what obligation the agent has to inform themselves of the particulars. A potential smoker may be aware that smoking is linked

to some diseases, but choose not to research the issue further. I believe there is a moral difference between those who are genuinely ignorant, and those who deliberately remain so.

An important aspect of Aristotle's moral philosophy is his focus on character. He believed that an agent's character determined their actions and that it was the agent who determined what kind of character they had. Returning to the example of Roger Smith, he murdered innocent people and then posed as a police officer. It appears that he is not ignorant of any of the particulars and therefore, is performing the action voluntarily. However, we know that Smith has been taught to act in a violent way. Aristotle believed that a person was responsible for his character, insofar as he was raised in optimal circumstances. Anyone who failed to receive the proper *paideia* or early education had little chance of being morally good. Therefore, Smith is not, or not completely, morally responsible for his character.

Aristotle's has given an account of voluntary and involuntary actions. An agent must be aware that they are performing the action for it to be voluntary. However, if an agent is ignorant of any relevant particulars then the action is involuntary. It seems that the agent must have some moral obligation to inform themselves of the particulars before they perform the action. Certainly, in a system where moral responsibility dictates health resource allocation, all subjects should ensure that they informed about health care issues.

1.2 The role of Alternate Possibilities

'A person may do something in circumstances that leave him no alternative to doing it, without these circumstances actually moving him or leading him to do it – without them playing any role; indeed, in bringing it about that he does what he does.' – Harry Frankfurt.¹²

Often, moral responsibility is determined based on the belief that the agent specifically selected that particular course of action from a number of options. The agent could have chosen to act in a morally acceptable way, but instead chose not to. This belief, that an agent is morally responsible as they had an alternative course of action available, is the known as the Principle of Alternate Possibilities. Harry Frankfurt rejects the Principle of Alternate possibilities, so has designed examples to show that an agent can still be morally responsible, regardless of whether they could have acted differently. He demonstrates that individuals can be morally accountable when no alternative action exists, that is, when they could not have acted in any other way. In this section, I will outline Frankfurt's examples.

The idea of *choice* is a significant feature of the Principle of Alternate Possibilities. When an agent decides to act they are making a *choice* and it is their choice that is subject to moral judgments. Without an alternative action available the agent had no choice, so says the Principle of Alternate possibilities. Therefore, there is no moral responsibility. Harry Frankfurt notes that this idea is linked to coercion, and the belief that it robs the individual of an alternative course of action. Frankfurt believes that what is most significant is, not whether the agent *could* have acted

¹² Frankfurt, Harry (1988) 'Alternate possibilities and moral responsibility' *The importance of what we care about* Cambridge University Press : United States of America Pg. 2

differently, but whether the agent *would* have acted differently had there been an alternate option.¹³

To illustrate his point, Frankfurt describes three agents; Agent A (AA), Agent B (AB) and Agent C (AC).¹⁴ AA is very headstrong and, once he has made his mind to perform an action, he will not falter from that decision. AA receives a threat commanding him to perform an action he already planned to perform. AA performs the action not based on the threat, but due to his previous decision. Frankfurt notes that this may seem like an example intended to refute the Principle of Alternate Possibilities, but AA did not act based on the threat. Instead, his motivation for acting was his previous decision. Thus, as Frankfurt states, AA was not deprived of an alternative course of action, as the threat did not affect him.¹⁵

The second agent, AB, also had made the decision to perform the same action, and he receives the same threat as AA. However, AB is very cowardly and, once he receives the threat, he acts upon the basis of the threat, rather than his own decision. Frankfurt believes that AB is morally responsible for the decision to perform the action, but not for performing the action itself as the impetus that caused him to act came from a third party. This is an example of coercion as AB acted based on the threat.

Frankfurt presents a final version of his example showing that even though the agent could not have acted in any other way, they are still responsible.¹⁶ Suppose an

¹³ Frankfurt, Harry (1988), Pg. 10

¹⁴ Frankfurt, Harry (1988), Pg. 3

¹⁵ Frankfurt, Harry (1988), Pg. 3

¹⁶ Frankfurt actually presents four individual cases, but I have chosen only to present three of them.

outside agent (OA) wants AC to perform a certain action so badly that he has hooked AC's brain up to a machine. The machine can force him to perform any action OA wants. OA, however, will only use the machine if AC acts contrary to his wishes. AC performs the action OA wants him to, without OA's intervention. In this example, AC had no alternate course of action because OA would have interfered if he tried to act differently.¹⁷ However, AC is morally responsible for the action for he was not aware of OA's interference, and he made the decision to perform it.

Using his final example, Frankfurt has shown that the presence of alternate possibilities is not sufficient for moral responsibility. Whilst it may be a relevant factor, there are times when agent's may act in the only way available but are still morally responsible. If we are to assign healthcare resources based on moral responsibility then we must examine what caused the agent to engage in unhealthy behaviour. If the agent made the decision to engage in unhealthy behaviour, even if there was no alternative available, then they could still be held responsible.

Frankfurt's examples have demonstrated a basis for holding individuals responsible even if they could not have acted differently. The significant factor is whether the individual wanted to engage in that particular course of action, or not. In the next section, I will discuss another issue pertaining to moral responsibility; acts of omissions.

1.3 Acts of Omission

¹⁷ Frankfurt, Harry (1988), Pg. 6-7

Acts of omission (or negative responsibility) are part of consequentialist theories of morality. Consequentialism focuses on the consequences of the agent's action, and a particularly well known consequentialist theory is utilitarianism. The goal of utilitarianism is to obtain the maximum amount of happiness. Thus, when considering a choice of action one must choose the action that generates the largest amount of utility, or happiness. Our actions are significant insofar as they have an affect on the total amount of utility.¹⁸ An action is morally good if it creates a large amount of utility.

According to J.R Lucas, there are some merits to the consequentialist doctrine; we are as much responsible for the consequences of what we do as we are for what we fail to do.¹⁹ However, Lucas notes that this falls into the trap of the doctrine of unlimited negative responsibility. To be morally responsible for the consequences of not acting could make everyone responsible for every problem that they are capable of solving, yet fail to solve. Issues such as global warming, world hunger and animal cruelty become *every* individual's responsibility. Lucas believes that this places an unfair burden on us as moral agents.²⁰

I believe that if an individual is as much responsible for failing to ensure good health, as they are for initiating ill health then an account of negative responsibility is required. This means that the individual, who fails to apply sunscreen and develops skin cancer, is just as responsible as the individual who smokes and develops lung cancer. One might object and assert that this places an unfair burden on the individual who not only has to avoid unhealthy behaviours, but actively partake in healthy ones.

¹⁸ Lucas, J. R (1993) *Responsibility* Oxford University Press : United States of America Pg. 34-5

¹⁹ Lucas, J. R (1993), Pg. 36-7

²⁰ Lucas, J. R (1993), Pg. 38

Fischer and Ravizza also discuss acts of omission in their work. They identify that the scope covering acts of omissions can be wide or narrow. The wide theory would suggest that whenever a person fails to do something, they are responsible for what they fail to prevent.²¹ For example, if a person is not actively stopping world hunger then they are responsible for world hunger, or in the case of healthcare, if the patient consciously chooses not to try and prevent their ill health they should be held responsible for any resultant illness.

Agents should be held responsible for acts of omission if they believe that performing the action, that they fail to perform, will prevent ill health. It is not important if the agent could have successfully prevented ill health, but rather, whether or not the agent believed they would have been successful. If the agent is not aware of any factors preventing their actions from leading to good health, then they should perform those actions. An individual may be aware that applying sun block reduces the risk of skin cancer however, that individual may still choose not to apply sunscreen. The individual may later develop skin cancer resulting from genetic factors, rather than their exposure to the sun. It seems unfair to hold them responsible for skin cancer developed from genetic factors, but they are still morally responsible for their act of omission. This may not affect their entitlement to treatment for skin cancer, but could affect their claim to future treatment.

Social policy makers will need to determine how far they wish to take the theory. However, these arguments show that there is a moral justification for holding

²¹ Fischer, John Martin and Ravizza, Mark (1998), Pg. 124

people accountable for acts of omission, as long as the acts directly lead to ill health. It is only fair to hold moral agents morally responsible for acts of omission, but not everyone is a moral agent. Some individuals will be exempt from moral accountability due to mental health problems, or disabilities. The next section will discuss another group of individuals, whose status as moral agents is questionable; children.

1.4 Moral responsibility and children

Sir Peter Strawson and Aristotle assert that to be morally responsible is to be an appropriate candidate for the reactive attitudes associated with moral responsibility. This leads to an important question for this project; are children appropriate candidates? This question is significant as many individuals choose to engage in unhealthy behaviours as children, which in turn, affect them as adults.²² For example, every year 8,000 New Zealanders under the age of 16 will begin smoking and the average age is 14 years old. By age 18, two thirds of these smokers will regret becoming addicted and half will have tried to quit.²³ There is a problem over whether those that begin smoking at a younger age should be held as responsible as those who begin as adults.

To find some answers to the question of moral responsibility of children, this issue will be discussed. Peter Strawson asserts that children are not morally responsible. Susan Dwyer delves into this problem in her paper, written as a reply to

²² Strawson, P. F (1974) 'Freedom and Resentment' *Freedom and Resentment and other essays* Methuen & Co. Ltd. : London

²³ http://www.cancernz.org.nz/uploads/MediaRelease_DVD_release_FINAL.pdf. Date accessed 20 August, 2009.

Strawson's 'Freedom and Resentment' essay. Dwyer believes that Strawson fails to account for how humans become moral agents.

It is clear that children are not fully morally responsible agents, and it is also clear that fully developed adults are. What is not clear, however, is when one actually becomes a moral agent, that is, when is one no longer a candidate for diminished responsibility because of their age. This process does not occur overnight. Strawson suggested that adults are moral agents because they are the appropriate candidates for reactive attitudes, however, Dwyer believes this is vague, there must be something about the agent which makes them an appropriate candidate.²⁴

According to Dwyer; a capability for action, for one's action of manifest good or ill will to others, and a grasp of what counts as good or ill will towards others, are all required for an agent to be an appropriate candidate for reactive attitudes.²⁵ Dwyer suggests that reactive attitudes are reciprocal; a person who holds themselves to moral standards also expects others to be bound by them.

Dwyer references several studies showing that children begin to adhere to moral standards as early as age two. The study demonstrated that whilst children demonstrated moral inclinations, they were not fully developed. When given an example of a criminal who had stolen a toy the younger children believed the perpetrator would feel happy about the crime. At sixth grade level, the children now recognised that the perpetrator will have mixed emotions, such as guilt.²⁶ These studies would perhaps indicate that children have some capability for moral reasoning

²⁴ Dwyer, Susan (2003) 'Moral Development and Moral Responsibility' *The Monist* Vol. 86 Pg. 185

²⁵ Dwyer, Susan (2003), Pg. 185-6

²⁶ Dwyer, Susan (2003), Pg. 188-190

(whether this is through nature of nurture remains a question). As they grow older, this moral reasoning continues to develop until they become full-fledged moral agents. This suggests that children become gradually more morally responsible. Therefore, if we were to place children on a continuum of responsibility, they would fall at different places as they grow older, that is, what a child may not be held responsible at two years old they will be held responsible at six years old.

The problem with this conclusion is that there is no clear point at which a child becomes morally responsible. This can cause difficulty when trying to assign responsibility for health states. As no clear answer can be postulated, I believe that cases will need to be assessed on an individual basis rather than by drawing an arbitrary line in the sand. I will discuss the concept of degrees of responsibility in the final chapter, where I propose a system that would solve these problems.

1.5 Walter Glannon on Moral Responsibility

Walter Glannon suggests that if an agent has causal control over their behaviour they can be held responsible for any ill health that results. He identifies a total of five conditions which he believes are necessary for causal control. These conditions provide the most compelling account of moral responsibility for health states, and could be used effectively when implementing responsibility for health as social policy.

According to Glannon, retrospective and prospective factors need to be considered when assigning healthcare resources.²⁷ Retrospective factors concern how the patient developed the condition, and prospective factors affect their future claim on the resources, that is, whether or not they are medically the best recipient. For Glannon, an agent is morally responsible if they were able to exercise causal control over their decisions or whether the alcoholic was able to exercise causal control over the decisions which led to their alcoholism.²⁸

There are four key components, Glannon identifies as amounting to causal control;

1. The decision must be free from coercion.
2. The individual must have autonomy.
3. The individual must have the cognitive capacity to foresee the potential consequences of their decision.
4. The decisions made need to have resulted in the individual's development of that condition, that is, if acting differently could have prevented the illness then they are causally responsible.

If the agent satisfies these conditions then they can be held morally responsible. It seems fairly clear how an agent can be held responsible for their actions under such a system, but can Glannon's conditions be applied to acts of omission? The first condition states that an agent must be free from external and internal coercion. External coercion could include extreme factors such as torture, or less extreme such as peer pressure. These factors must be so severe that the agent feels they have no

²⁷ Glannon, Walter (1998), Pg. 32

²⁸ Glannon, Walter (1998), Pg. 33

other choice but to perform the action.²⁹ I imagine this would be a rare occurrence in the case of an act of omission. However, children could be indoctrinated to believe that certain healthy behaviours are actually unhealthy for them and thus, not engage in them. These individuals would be held less accountable for their actions than those who knew the behaviours were healthy but chose not to act. Internal coercion would apply to instances of mental illness or possibly addiction.³⁰

The second condition requires that the agent has autonomy. Autonomy can be defined as self-government or self rule.³¹ Medical autonomy is the right of patients to make their own decisions about their medical care.³² Glannon believes that this does not go far enough, so adds that the agent must have the capacity for reflective self-control and the ability to reflect on one's decisions.³³ The decision made by the agent must reflect their beliefs and desires, thus they are responsible for that decision. Beliefs and desires may alter over time, so the agent must have the capacity to change their behaviour in order to reflect this.

Will Cartwright discusses the concept of self-reflection. He suggests that in order for a desire to be authentically the agent's it requires authorship. Humans not only possess consciousness but self-consciousness which gives us the capacity to reflect on our desires and beliefs.³⁴ By reflecting on our desires, we effectively endorse them, and make them our own. Desires are endorsed by reflecting on them

²⁹ Glannon, Walter (1998), Pg. 34

³⁰ The issue of addiction is extremely complex and so shall be dealt with in a separate chapter (Chapter 5).

³¹ Mautner, Thomas (1996) *The Penguin Dictionary of Philosophy* Penguin Books : England Pg. 53

³² <http://www.medterms.com/script/main/art.asp?articlekey=13551>. Date accessed 4th October, 2008.

³³ Glannon, Walter (1998), Pg. 34

³⁴ Cartwright, Will (2006), Pg. 145

and deciding whether we approve or disapprove of them.³⁵ This theory appears originally in Harry Frankfurt's work. He claims that a *person* is someone who has second order volitions. A second order volition involves wanting to have a certain desire; this is a reflection of the agent's will.³⁶ An agent's desire is truly his when he has made the decision autonomously and formulated a desire for it. The desire needs to have been evaluated by the agent and the agent must identify with it.

This conception of moral responsibility reinforces Dwyer's findings, that children are not fully responsible moral agents. Their ability to reflect on their desires is impaired by a lack of information and understanding. This also applies to the mentally retarded, who have impaired capacities. Children and the mentally retarded should not be held responsible for their decisions unless they have an ability to self-evaluate and understand the potential consequences of their actions. As I discussed in the previous section, children gradually become more morally responsible as they age. Provided the agent had the necessary capacities, Glannon's second condition can be applied to an act of omission.

I mentioned the third condition briefly when discussing the second, that is, an agent must have the ability to foresee the consequences of their actions. Not only does this condition require certain mental capacities, but also the correct information. If an agent makes a decision on incomplete or incorrect information then it is possible that they could not have foreseen the consequences of their actions. Once they learn that their actions do have harmful consequences under the proposed system, the expectation is that they will change their behaviour. If an agent found out that by not

³⁵ Cartwright, Will (2006), Pg. 145

³⁶ Frankfurt, Harry, (1988) 'Freedom of the Will' in *The Importance of what we care about* Cambridge University Press : New York Pg. 16

performing a certain action they could develop ill health, then the agent will be expected to change their behaviour. If not, they would be held responsible for any resultant ill health.

The fourth condition holds that the agent should only be held morally responsible for any illnesses which developed as a result of either their actions or acts of omissions. For example, it would not be fair to hold the smoker accountable for developing un-related skin cancer because they are a smoker, and acting unhealthily. If the condition cannot be linked to the patient's unhealthy behaviour then it is not fair to hold them morally responsible.

Glannon adds a fifth condition relating to the implementation of the proposed system. This condition requires that the patient be aware, not only that their behaviour will lead to a diseased state, but that they may also receive some sort of penalty in the healthcare system.³⁷ This calls for consistency within the system. It also necessitates that all individuals have access to updated healthcare information and are aware of how healthcare resources are distributed, which requires a robust programme of preventative medicine educating everyone on how to act in healthy ways.

The five conditions proposed by Glannon give us a concrete account of whether or not a patient is morally responsible for their illness. His conditions can be applied to acts, and acts of omission. They have also shown that children and the mentally retarded are not causally responsible for their decisions. They identified certain requirements for a system of resource allocation based on personal

³⁷ Glannon, Walter (1998), Pg. 34

responsibility; the public must have access to information about healthcare and maintaining a healthy lifestyle.

1.6 Conclusion

This chapter began with the case study of Roger Smith. Smith's story showed that responsibility attribution is not black and white, and that it is affected by the amount of information regarding retrospective factors. It may initially seem that Smith is responsible for his terrible actions, but once more information is known about his childhood this reaction is questioned. The story demonstrated that responsibility attribution is variable, from person to person, which is why trying to find a theory of moral responsibility that applies to all cases is very difficult.

Next, Aristotle's moral responsibility theory was discussed. Aristotle identified a voluntary moral action as one for which an agent can legitimately receive praise or blame. Aristotle makes a distinction between acts that one can be held accountable for, and those that they should not. He also postulates a list of particulars of which an agent can be ignorant, rendering the agent's action involuntary. If a person is ignorant of any one of the particulars then they are not morally responsible.

Aristotle believed that when committing an act under coercion an agent could still be morally responsible. When being coerced an agent still had a choice between options; not acting, or making the hard choice. Harry Frankfurt's examples showed that moral responsibility can still be attributed, even when an alternative course of action is available. Thus, Frankfurt rejects the Principle of Alternate Possibilities.

Acts of omission were discussed next. I believe this is a significant problem as many people chose not to act to prevent ill health, for example, failing to apply sunscreen to prevent skin cancer. I, initially, believed that people should only be held responsible for their acts of omission if, had they acted, they would have been able to prevent their ill health. I concluded that agents should only be held responsible for conditions, which develop from their deliberate choice not to act. If their actions could have prevented ill health, then they should be held responsible.

Discussion then turned to the moral development of children. Young children are not held to the same moral standards as adults. However, many adults suffer from ill health resulting from decisions made as children. It is unclear at what stage one ceases to be a candidate for diminished responsibility, and become a full-fledged moral agent. Susan Dwyer showed that children do have moral inclinations as early as age two. I concluded that children are morally responsible for actions in differing degrees. I will discuss the idea of degrees of moral responsibility in the final chapter.

Finally, I presented Walter Glannon's account of causal control. He believes that an agent can be held morally responsible for any decisions which they had causal control over. His conditions are the most pertinent to responsibility, and give a fair account of holding individuals morally responsible. However, distribution of medical resources based on moral responsibility still has several challenges to overcome. One of the most pressing; that everyone has a right to healthcare.

Chapter Two: A right to health care?

'...medical care is sometimes given or denied according to the ability to pay, or according to legal entitlement. In some cases of outright discrimination, care is denied because of race. But almost never are patients systematically rejected because of their role in the origin of their illness.' - Daniel Wikler³⁸

2.0 Introduction

The moral responsibility argument revolves around the idea that there is something morally significant about causing one's ill health. These people need to be treated differently, that is, they ought to be held accountable for their actions. This ensures they are not consuming more than their allocated fair share of resources. However, one strong objection to this is the assertion that, regardless of lifestyle habits, everyone has a right to health care.

Briefly constructed, the main points of the argument, for holding people morally accountable for their health states, are as follows:

- 1) Some patients are morally responsible for their medical conditions.

- 2) Patients who have caused their medical conditions are using more than their fair share of resources.

³⁸ Wikler, Daniel 'Personal Responsibility for Illness; Pg. 326-7

3) It is unfair for people who are not morally responsible for their medical conditions to receive fewer resources, because of (2).

4) It is reasonable to hold those who satisfy condition (1) morally responsible for their illnesses.

Therefore, 5) it is reasonable to expect those who are responsible for their medical condition to restore the resources they unfairly deplete.

Some authors take issue with (4), as they believe that everyone is entitled to health care regardless of moral considerations. In this chapter, some of the problems with the right to health care are discussed. Mark Siegler does not believe there is a right to healthcare. However, given that there is some controversy over the existence of a right to health care, I have decided to assume that one exists. Therefore, two arguments are presented that justify overriding this right. One is Samantha Brennan's account of rights thresholds, and the other argues that receiving the benefits from a right requires moral obligations of the bearer.

2.1 The right to health: Positive or Negative?

Most people believe that every individual has certain basic rights (although, they may disagree about what these rights actually entail). These can be divided into

positive and negative rights.³⁹ Positive rights concern the right to have or obtain certain things, and place corresponding obligations on others to provide those things. This usually encompasses the basic needs which a human being requires in order to survive. Lippke suggests that positive rights are those that are vital conditions for agency.⁴⁰ Negative rights are different from positive rights as they are not rights to tangible things, but rather include the right to freedom from interference, and so forth. Libertarians would suggest that individuals only possess negative rights, rather than positive rights.⁴¹

According to the above distinction, the right to healthcare is a positive right, as it requires the provision of healthcare resources. Positive rights require more of the right provider than negative rights. The provider has a duty requiring them to provide the resources to ensure that right. A negative right simply involves the right provider leaving the right bearer alone. Therefore, if the right to healthcare is a positive right someone has a duty to provide that right.

Andrew Cooper notes, in his thesis regarding the human right to healthcare, that the right to health cannot be *absolute*.⁴² An *absolute* right is one that must always be satisfied, regardless of competition with other rights. If an *absolute* right to healthcare exists then, according to Cooper, 'medical black holes' are created. To clarify, if the right to health is *absolute* anyone who is sick is entitled to health care

³⁹ Lippke, Richard L (1995) 'The Elusive Distinction between negative and positive rights' *The Southern Journal of Philosophy* Vol. 33, Issue 3, Pg. 335

⁴⁰ Lippke, Richard L (1995), Pg. 335

⁴¹ Lippke, Richard L (1995), Pg. 335

⁴² Cooper, Andrew (2007) *The Human Right to Healthcare: A distributive cliché* A thesis submitted in partial fulfilment of the requirement for the degree of Master of Arts in Philosophy in the University of Canterbury. Pg. 32 Cf. Denier, Yvonne (2005) 'On Personal Responsibility and the Human Right to Healthcare' *Cambridge Quarterly of Healthcare Ethics* Vol. 14, Pg. 227 'The right to healthcare cannot be an unlimited right.'

treatment. However, there are often cases when healthcare treatment cannot restore good health, for example, a terminally ill patient. An *absolute* right to healthcare entitles a terminally ill patient to unlimited resources in an attempt to restore their health (the treatment can only cease once the patient is dead). If this was common practice, then funding for medical resources would be exhausted, and funds would be diverted from other areas.⁴³

Cooper suggests that rather than consider the right to healthcare a positive right, it is instead a *prima facie* right.⁴⁴ A *prima facie* right is one that gives way when in competition with other rights. This contrasts with an *absolute* right, which can never be ‘trumped.’ An example of a *prima facie* right is a terminally ill patient who chooses to forego their right to healthcare, in favour of their right to die with dignity. Overriding the right to healthcare sometimes occurs without the patient’s consent, for example, triage principles used in emergency cases. During World War II only a limited amount of medical resources was available and not all received treatment. As a result, those whose injuries were fatal would often only receive pain relief in order to preserve resources for those soldiers who had a chance of survival.

Thus far, I have shown that the right to healthcare is problematic. It cannot be a positive *absolute* right. Instead, the right to health is *prima facie* and, when in competition with other rights, it can be overridden. In the next section, Mark Siegler’s arguments demonstrate that the right to health care is ambiguous, and undermines the doctor/patient relationship.

⁴³ Cooper, Andrew (2007), Pg. 32

⁴⁴ Cooper, Andrew (2007), Pg. 32

2.2 Mark Siegler: A right to...what?

Whether or not healthcare is a matter of right has been the subject of much debate. There is also a question of whether the right to health is negative or positive *prima facie*. According to Siegler, there is an ambiguity over what the 'right to health' actually is, and so suggests three possible options:

- 1) A right to health. This is distinct from a right to health *care* as it implies that all individuals are entitled to a specific level of health.
- 2) A right to healthcare, that is, the kind of care often associated with the health enterprise. This refers to the activities of healthcare such as doctor's appointments, operations, and so forth.
- 3) They may be requesting care of the sort associated with health care activities provided by health professionals.⁴⁵ This is the care that the healthcare professionals provide their patients by tending to their needs, empathising with them, making sure they feel happy, et cetera.

Conditions (1) and (2) have the greatest significance to the topic. Both involve the provision of certain resources, and therefore are positive rather than negative rights.

If the claim for the right to health is that of simply health itself, then this has many implications. Health is required for life and includes many things. It also means

⁴⁵ Siegler, Mark (1979), Pg. 48

different things for a first world, as opposed to a third world country. Aspects of healthcare not only include treatment from medical practitioners, but also access to clean drinking water, vaccinations, fresh fruit and, vegetables, and so on. Without health, one cannot be autonomous, and if its citizens are not healthy then the State cannot function. Human beings have a great amount at stake when it comes to health.

As mentioned earlier, a positive *absolute* right to health is implausible. With already limited resources, the State cannot channel all it has into fulfilling a positive right to health. Domestically, the State provides not only subsidised healthcare, but also the means to health by way of access to clean water. They also provide welfare so that those who cannot work are able to afford food and shelter. However, if the State were to channel all its resources into fulfilling a positive *absolute* right to health then this could result in State bankruptcy. Then there would be no healthcare resources for anyone. In order for the right to health to be viable it needs to be able to ‘give way’ in favour of other rights. Therefore, the right to health or healthcare is positive *prima facie*, as it involves the provision of resources.

In the previous two sections, I discussed some of the problems relating to the right to healthcare. However, this issue is still highly controversial, so for the rest of the chapter I will assume there is a positive *prima facie* right to healthcare. Given this assumption, I will argue that this right can be permissibly overridden in two ways – the first; by using Samantha’s Brennan’s account of rights thresholds and the second by claiming that, if a person has a right to free healthcare and chooses to engage in unhealthy behaviour, they have forfeited the benefits of the right.

2.3 Justifiable infringing the ‘right to health’

Assuming that a right to health exists requires an account of how this right can be infringed. In this section, I will outline two such justifications. The first, is Samantha Brennan’s account of rights thresholds. The second, shows how some rights have associated duties. If these duties are not upheld, then the right is ‘forfeited’ by the bearer.

2.3.1. Samantha Brennan and rights thresholds

Brennan’s account of rights thresholds demonstrates when a *prima facie* right can be justifiable infringed – the right’s *threshold*. An infringement is distinct from a violation, as an infringement is justified but a violation is not.⁴⁶ I have already stated that it is sometimes permissible to infringe a right when there are other competing rights at stake. For example, when a patient has their right to harm violated in favour of their right to life, like the removal of a limb in order to prevent a harmful flesh-eating bacteria from killing them.

Under Brennan’s distinction, there are three roles when discussing infringing a right; the right infringer, the right bearer and the beneficiary. To illustrate these roles, I will outline an example of a liver transplant. Sandra developed liver disease due to a genetic condition. She has lived a relatively healthy lifestyle; engaging in exercise on a regular basis, eating healthy food and avoiding drugs and alcohol. Jack developed

⁴⁶ Brennan, Samantha (1995) ‘Thresholds for Rights’ *The Southern Journal of Philosophy* Vol. 23, Pg. 149

liver failure, resulting from alcoholism. He had access to rehabilitation programs but chose not to seek help.

Both patients are at the top of the transplant list when a liver becomes available. Taking the position that every individual has the right to healthcare, both Sandra and Jack are the right bearers, and both have a claim on the organ. In this case, the right infringer would be the committee that allocates the organ. The beneficiary is the patient who receives the organ if the right to health care is infringed.⁴⁷ Given the proposal, that those who are morally responsible for their ill health should receive reduced entitlements to healthcare, Sandra should receive the liver and, therefore Jack's right to health care is infringed.

The idea that rights have thresholds can be clearly illustrated with the following thought experiment. Traditionally, the right to life is an inviolable right, and it seems there are no situations when this right can be violated.⁴⁸ However, consider a situation in which 1,000 lives will be saved by killing one person. Perhaps some will say that it is permissible to violate that one person's right to life, and others might say that it is not permissible. Then, consider a case in which 1,000,000 lives are at stake. Surely those who said that it is not permissible to violate the right to life when 1,000 lives are at stake will not agree that it is so black and white when 1,000,000 lives could be saved.⁴⁹

⁴⁷ I acknowledge that in these cases the recipient is usually the best candidate, so therefore A would receive the organ. Given the likelihood of relapse, B may not be considered for a transplant.

⁴⁸ Brennan, Samantha (1995), Pg. 145

⁴⁹ Brennan, Samantha (1995), Pg. 147

The above example intends to demonstrate that rights have thresholds. These thresholds are the point at which the right ‘gives out’ and can be infringed, justifiably. The justification relies on utilitarian considerations, as infringing the right must create a larger amount of utility than the disutility created by the right infringement. I acknowledge that this justification may not impress hard-line deontologists. However, even Robert Nozick concedes that some rights give way in cases of ‘catastrophic moral horror.’⁵⁰

There remains a question over whether the right to healthcare even has a threshold. Brennan suggests that in order to have enough at stake to infringe a right two conditions must be met; the universal and the existential constraint. The universal constraint as described by Brennan:

‘In order to have what they have at stake count towards infringing a right, each and every beneficiary must have a minimum amount at stake. This ‘universal constraint’ acts to modify and constrain the total requirement. (It is called the *universal* constraint since it dictates a minimum that *each* and *every* of those who benefit from the right infringement must have at stake, if what they have at stake is to count towards the total.)’⁵¹

The universal constraint occurs when every *beneficiary* (or anyone who will benefit from the right infringement) has a minimum amount at stake, for example, in the case of the liver transplant one could say that the other beneficiaries include the patient’s friends, family, colleagues, and many more. The public also has something to gain, that is, if the man who receives the transplant has lived a healthy lifestyle then the members of the public who have lived a healthy lifestyle will receive resources on

⁵⁰ Brennan, Samantha (1995), Pg. 145

⁵¹ Brennan, Samantha (1995), Pg. 151

the same basis. Those who live healthy lifestyles are all beneficiaries of this system, and have their future healthcare at stake. Especially, if there are not enough resources to share amongst everyone.

Anyone who could be a beneficiary must have something riding on the outcome of infringing the right. However, this is not sufficient for infringing the right. For example, it is not permissible to infringe someone's right to life in order to prevent a large group of people from receiving broken arms. Here, the universal constraint is satisfied, but infringing the right is still not justified. Something else is required to justify infringing the right.

Brennan develops a second constraint; the existential constraint. The existential constraint requires that at least one person, who has an amount at stake, must have an amount proportional to what the rights bearer has at stake.⁵²

'Call this restriction on the total amount the 'existential constraint.' (The name 'existential constraint' is meant to contrast with the universal constraint. While the universal constraint applies to *all* those who would benefit from a right infringement, the existential constraint is satisfied when *one* person who will benefit from the right infringement has enough at stake.) I have in mind that a plausible version of this constraint would say that there must be one person amount the beneficiaries who has at least as much at stake as the rights bearer.'⁵³

Therefore, if a person has their life at stake then one other beneficiary must also have their life at stake. Returning to the liver transplant example, both the universal and the existential constraint has been satisfied, as both patients have their lives at stake. The

⁵² Brennan, Samantha (1995), Pg. 153

⁵³ Brennan, Samantha (1995), Pg. 153

universal constraint is satisfied because everyone involved has at least a minimum amount at stake. The existential constraint is satisfied because Sandra has her life at stake.

It would not be possible to reverse the argument, and claim that Jack could also infringe Sandra's right to the liver, as the universal constraint is not met. If Sandra receives the transplant then the public has something at stake, as they would want to receive the same treatment when in competition with another patient who was guilty of creating their need for the transplant. In Jack's case, the public does not have anything at stake, so the universal constraint is not satisfied.

In order to infringe a right, both the existential and the universal constraint must be satisfied. This gives us a clear indication of what to do when an 'innocent' individual and a 'guilty' individual both require the same level of treatment, and there is only one resource available.⁵⁴ This will need to be applied case by case to ensure all parties identified, and the universal and the existential constraint met. The argument shows that it is permissible to infringe a person's right to healthcare, when medical resources are scarce. The argument, that everyone has a right to healthcare, does not defeat the moral responsibility argument.

The essential points of the previous discussion follow:

1. There must be a right-bearer, a beneficiary and a right infringer.
2. Within the group of beneficiaries, the universal constraint is to be satisfied.

⁵⁴ Please note that any reference to guilt or innocence within this paper is an attempt to distinguish between those responsible for their injuries or illnesses, and those not responsible.

3. One member of the group of beneficiaries must meet existential constraint.
4. When the above conditions are met, the right can be justly infringed.

Each situation of rights infringement must satisfy a list of conditions. Brennan has given us a plausible argument justifying a right's infringement, under certain conditions. Discussion will now turn to another justification for infringing the right to health care; the right to healthcare confers associated duties on the recipient.

2.3.2 Our duty to maintain our health

As stated earlier it will be argued, not only that rights can be justifiably infringed, but also that if a patient is responsible for their injuries or illness they have 'forfeited' their right to healthcare. Mark Siegler suggests that providing a right to healthcare will bring about a decline in our sense of personal accountability for conditions, such as alcoholism, drug addiction, obesity, child abuse, ugliness, anxiety, and unhappiness.⁵⁵ If this is the case, then there is even more at stake in proving a case that those who are responsible for their conditions should be held accountable.

Sometimes when an individual has a positive right, they must perform certain actions in order to receive the benefits from that right. An individual may have the right to education, but they still have to attend school, pass their examinations, and so forth, in order to receive the benefits of the right. A right to education does not automatically grant university entrance, or a high school diploma; such honours are

⁵⁵As the limits of health expand, and the sense of personal responsibility declines, physician interventionism, and perhaps a form of medical paternalism, increases.' Siegler, Mark (1979) 'A Right to Health Care: Ambiguity, Professional Responsibility, and Patient Liberty' *Journal of Medicine and Philosophy* Vol. 4, Number 2, Pg. 155

earned. To receive the benefits from a positive right one must fulfil certain moral obligations. This obligation is a strong moral principle.

Application of this moral principle, to the right to healthcare, suggests that individuals may have a right to healthcare, but they might also have a moral obligation not to cause ill health. When an individual chooses to engage in unhealthy behaviour, they are not fulfilling their moral obligation. Therefore, the individual is choosing to *wave* their right to health care. This is not to say that those who are sick should not receive medical attention, but rather that it is no longer a matter of right as to whether they receive it.

The case of two patients (Oscar and Michelle) illustrates this idea. Both patients have a history of heart disease in their family. Oscar and Michelle both receive the same advice from their doctor; take preventative medication, check blood pressure regularly, partake in regular exercise, and consume a healthy diet. Oscar follows the doctor's advice to the letter, but Michelle does not. Michelle chooses to live a particular lifestyle over her right to healthcare, so she is morally culpable for the costs. The reason; Michelle is acting contrary to the best interests of her health. Even though she could have taken the doctor's advice, potentially preventing her illness, she chose not to. If Oscar develops heart disease, after following the doctor's advice to prevent it, he is not morally responsible for his sickness.

Nora K. Bell discusses the issue of rights implying associated duties, 'Right to healthcare cannot be an undeniable right, no matter whether the system is just or unjust, for if the individual does not do what is required of him by the rules he no

longer has a claim recognised as legitimate with the system as it is defined.’⁵⁶ She describes the right to health as a transaction in which two parties partake; the patient, and the medical institution. The patient may have the right to health, but the institution also has something at stake. If the patient refuses to comply with their treatment plan, then the institution has a right to hold them accountable.

Bell sees it as ‘perfectly permissible’ for institutions to hold patients accountable for their own health states, particularly in the case of scarce medical resources.⁵⁷ This means responsibility for the right to health lies with both parties, rather than just the medical institution. A right involves certain moral obligations, and if an individual chooses not to fulfil these, then the provider of the right is no longer obligated to provide it. This can apply to negative rights, also. If an individual has the right to freedom from interference, they are also morally obliged not to interfere with others. If they do interfere with others, they no longer possess the right to freedom from interference, that is, they may be incarcerated. As Bell states ‘one’s personal health is his personal responsibility and access to health care (or one’s right to health care) may be circumscribed, particularly in conditions of scarcity, by requirements for the exercise of that individual responsibility.’⁵⁸

2.4 Conclusion

⁵⁶ Bell, Nora K. (1979) ‘The Scarcity of Medical Resources: Are there rights to health care?’ *The Journal of Medicine and Philosophy* Vol. 4, Number 2, Pg. 167

⁵⁷ Bell, Nora K. (1979), Pg. 167

⁵⁸ Bell, Nora K. (1979), Pg. 167

Within this chapter, discussion has focussed on the right to health care. There is some question over whether or not this right actually exists. Andrew Cooper argues that a positive *absolute* right to healthcare is implausible, as it creates medical 'black holes.' This thesis proposes a way of preserving health care resources, rather than depletion, therefore the right to health care must be positive *prima facie*. A *prima facie* right can 'trumped' by other competing rights.

Mark Siegler rejects the right to healthcare, as he believes it is ambiguous. Siegler identifies three possible versions of this right: a right to health, a right to health care, and a right to healthcare. Given this ambiguity, it is possible that the right to healthcare does not exist. Although the rest of the chapter assumes a right to healthcare, Siegler's discussion demonstrates the controversy surrounding this issue.

The right to healthcare is *prima facie*, which means that it can be 'trumped' when in competition with other rights. Two arguments were presented which demonstrate when such 'trumping' is justified. Samantha Brennan identifies that all rights have a threshold. The threshold is the point when a right 'gives out.' Brennan develops two conditions: the universal and the existential constraint. These, once met, justify the infringement of the right.

The second justification for a right's infringement lies in the behaviour of the right bearer. Rights can require stringent moral obligations of their bearers. For example, an individual may have the right to healthcare, but they also have an associated moral duty not to actively cause their ill health. To do so, places an unfair

burden on the right provider, as they now have to provide a greater amount of resources than previously. Therefore, if the right bearer chooses to engage in behaviour, which causes ill health, they must also concede their right to health care. Effectively, the right bearer values the risky behaviour over their right.

This second justification is a strong argument for the allocation of medical resources based on moral responsibility. Those who choose to engage in unhealthy or risky behaviours have a choice; if they undertake the behaviour, they forfeit their right to treatment. As was stated earlier, they may still receive medical treatment, but no longer as a matter of right. As such, they may be required to fund a portion, or all, of their treatment costs.

Initially, the right to health seemed like a strong objection to allocation of resources based on moral responsibility. Further investigation into this issue has revealed that a right to health, or health care, may not even exist. Assuming that it does exist has shown that, in certain situations, infringing this right is justified.

Chapter Three: Objections to the Moral Responsibility Argument

3.0 Introduction

The moral responsibility argument is; if a person lives in a country, which subsidises healthcare then they should receive it at the subsidised rate. If a person engages in harmful behaviour, and becomes sick due to their actions, then they are consuming more than their fair share of resources. As a result, they have waived any right to subsidised healthcare. The patient may now have to pay some, or all of the costs of their treatment, and when in direct competition with others may not receive resources at all. The amount they pay for their treatment will depend on their degree of moral responsibility. The theory does not intend to deny the patient healthcare completely, but rather attempts to recover costs for resources, so they can be redistributed to those who have become sick beyond their own control. Thus, the distribution of health care resources is just, and allows governmental healthcare funding to continue as sustainable practice.

It is important to make some distinction between responsibility and accountability. A person can be causally responsible for an action, but not held morally accountable.⁵⁹ For example, an agent might accidentally knock over a friend's Ming vase. The friend may hold the agent causally responsible for the action; the friend knocked over the vase, but they may not request a replacement, that is, not hold them accountable. Accountability generally involves some sort of reparation. Within the thesis, holding an agent accountable is also known as 'holding someone

⁵⁹ Distinction found in Roemer, John E. (1998) *Equality of Opportunity* Harvard University Press : United States of America

responsible.’ I acknowledge that causal responsibility and moral accountability are distinct concepts, but they have been used interchangeably within this thesis.

This chapter will be concerned with some of the arguments against the moral responsibility theory. These include; John Harris’s views on punishment, Bruce Waller’s distinction between just-deserts and take-charge responsibility, the practical objections of Dien Ho, and the political objections of Daniel Wikler. Ho and Wikler accuse the theory of being paternalistic, so in the final section the arguments of Rosemary Carter and Simon Clarke are presented, to justify paternalism.

3.1 The Objectors

There has been plenty of debate regarding the role of moral responsibility within medicine. Many authors support, and many deride the policy. I discuss four objectors in particular, in this chapter. A fourth is discussed in the next chapter. The views of John Harris, Bruce Waller, and Dien Ho appear in the first section. Daniel Wikler’s objections are discussed in the second.

3.1.1 Punishing smokers: Double jeopardy and John Harris

John Harris is a strong objector to this thesis. He believes that this system cannot practically function, and that giving smokers lower priority for healthcare is effectively to punish them twice for the same crime. Harris also believes that there are issues of practicality, especially when applying the theory to emergency situations.

Harris argues that holding smokers accountable for their ill health unfairly punishes them twice, that is, ‘double jeopardy’.⁶⁰ Smokers are punished in the first, by getting sick, and are punished again through receiving lower priority for treatment. On the other hand, non-smokers are rewarded as they have a higher standard of overall health, and receive higher priority for resources. Harris believes that punishing smokers twice serves no purpose; if the harmful effects of smoking are not enough of a deterrent from smoking already, adding lower priority to the list will not achieve anything. Therefore, the only reason to push forward with such a policy is to *punish* smokers for their behaviour.⁶¹

The first criticism of Harris’s objection regards his assertion that smokers are *punished* for their unhealthy behaviour. Punishment is defined as the deliberate infliction of harm upon somebody, or the withdrawal of some good, in response to their committing of some offence.⁶² At first glance, it does appear that to hold smokers accountable for their ill health is to *punish* them for smoking.

Harris is incorrect to use *punishment* in this way. The system does not intend to *punish* people for engaging in unhealthy behaviour, but rather to protect others. If some groups want to engage in unhealthy behaviour then they may, but this behaviour is subject to associated costs. Not the cost of the product, but rather the risk associated with the behaviour. When a smoker is contemplating buying a packet of cigarettes, they have to weigh up the potential consequences with their desire to purchase the product. By purchasing the cigarettes, there is an agreement to pay the costs involved.

⁶⁰ Harris, John (1995) ‘Could we hold people responsible for their own adverse health?’ *Journal of Contemporary Health Law and Policy* Vol. 12, Pg. 149

⁶¹ Harris, John, (1995), Pg. 149-150

⁶² <http://www.oxfordreference.com/views/ENTRY.html?subview=main&entry=+98.e2585>. Date accessed 2nd February, 2010.

The proposed system suggests that this cost should be some portion, if not all, of their medical costs. Therefore, the smokers are not being *punished*, as such, but rather by purchasing the cigarettes, they enter into an agreement that may be enforced later. Further discussion on this topic appears in the following chapter (Chapter Four).

The other way to attack this argument would be to suggest that the above statement, that the harmful effects of smoking do not deter smokers, is actually false. Whilst, the harmful effects may not appear to be a deterrent, this could be due to a number of factors including, possibly, a belief that people only rarely get sick from smoking. Smokers may also rely on receiving medical treatment if they do get sick from their addiction.⁶³ To instigate a policy where smokers receive lower priority may give them extra incentive to quit smoking, especially when they no longer have a back-up plan.

While it may seem unfair that smokers become sick and are required to pay their health care costs; it is more unfair for those who have not caused their ill health to lose out because of those that have. If smokers are unfairly using more than their fair share of resources, there may not be enough resources left over to treat those who have not played a role in their illness. It is more unfair to use resources on smokers who could have prevented their ill health, than it is to require smokers to bear at least some of the costs of their medical treatment.

Harris raises another issue with a system of resource allocation based on moral responsibility; it runs into a problem of information. The problems arise when

⁶³ I acknowledge that smoking is a problematic example as it is classed as an addiction. The issue of addictive substances will be discussed in Chapter Five.

information required to assess moral responsibility is not available when required.⁶⁴ For example, at the scene of a car accident lives may be lost if moral culpability needs to be assessed, and the information is not available. Quite often, in such situations, there is no time to check for moral responsibility, and such assessments may take months to complete. For example, car accidents often require extensive investigations in order to ascertain who was at fault.

In emergency situations moral responsibility does not play a role and all parties will receive treatment. In such cases, I believe that triage principles should apply, and those with treatable injuries should receive medical attention. If it is not possible to treat all victims who have critical injuries, then those with the greatest chance of survival will receive medical attention first. Once the police have assessed responsibility, perhaps the accident was caused by drinking and driving, or one of the victims received serious injuries from not wearing a seat belt, then those who are responsible should be made to pay back the extra medical costs they incurred.

Harris notes in his paper that, if health care prioritisation became healthcare policy then everyone would be guilty to some degree as it is very difficult to engage in purely healthy behaviour.⁶⁵ Already discussed in chapter one, is the idea the moral responsibility is a matter of degree. Harris's objection only stands if health care resources are given, or denied, based on *any* level of responsibility. However, the system I have proposed will account for differing degrees of responsibility. Relevant factors will be examined, and help determine the degree of responsibility the agent

⁶⁴ Harris, John (1995), Pg. 152

⁶⁵ Harris, John (1995), Pg. 151

exercised. This level will determine what entitlement the agent has to subsidised health care, and what percentage of costs the agent will have to fund.

Overall, Harris's objections have not proven to be overly problematic. Harris suggested that it is unfair to punish smokers twice, but it is more unfair for those who have not caused their ill health to receive less because of the actions of those who have. I also disagreed that holding someone accountable for his or her ill health is akin to *punishment*. Harris argues that such a system cannot work practically. In particular, he notes the problem of emergencies. This is an easy objection to respond to; everyone receives treatment, culpability assessment occurs later.

In the next section, I will discuss the objections raised by Waller. Waller's objections are similar to Harris's. Harris argued that holding smokers morally responsible for their ill health would not change their smoking behaviour. Bruce Waller agrees, as he believes that holding individuals accountable for their health (just-deserts responsibility) will only encourage individuals to give up on themselves.

3.1.2 Bruce Waller on Just-Deserts vs. Take-Charge Responsibility

Bruce Waller objects to the theory on two main grounds; the first objection claims that environmental factors prevent a patient from being able to take charge of their health state, and the second objections rely on his distinction between just-deserts, and take-charge responsibility. Waller believes that just-deserts responsibility undermines take-charge responsibility, fails to generate positive results, and promotes self-handicapping.

Waller suggests that environmental factors affect a patient's ability to take charge of their own healthcare, so much that it is unfair to assign just-deserts responsibility.⁶⁶ He believes that cognitive ability and environmental factors are beyond a patient's control, and therefore should not affect whether or not an individual receives treatment.⁶⁷ This objection is deterministic in nature. 'Determinism is the thesis that all events and states of affairs are determined by antecedent events and states of affairs.'⁶⁸

If our environment dictates our choices then it is unfair to hold us morally accountable, for moral responsibility is non-existent. In the space allocated, I do not have time to discuss the merits of determinism, but other philosophers have already attempted to show that moral responsibility exists even if determinism holds true.⁶⁹ John E. Roemer suggests a way to account for environmental and other factors beyond an individual's control using his 'Equality of Opportunity' theory. This will be discussed in the final chapter (§ 6.2).

Waller believes that just-deserts and take-charge responsibility have been confused.⁷⁰ Take-charge responsibility involves patient 'taking responsibility' for their health. When it is said that an alcoholic needs to 'take responsibility' for their condition, what is really being stated is they need to exercise take-charge

⁶⁶ Waller, Bruce N. (2005), Pg. 182

⁶⁷ Waller, Bruce N. (2005), Pg. 180-2

⁶⁸ Mautner, Thomas (ed.) *The Penguin Dictionary of Philosophy* 'Determinism' Penguin Group : England : 1996 Pg. 137

⁶⁹ See Fischer, John Martin and Ravizza, Mark (1998) *Responsibility and Control: A Theory of Moral Responsibility* : Cambridge University Press : United States of America

⁷⁰ Waller, Bruce N. (2005), Pg. 178

responsibility.⁷¹ Just-deserts responsibility involves being held responsible by an external source, or getting your ‘just deserts.’ In this sense, the moral responsibility I speak of within this thesis is akin to Waller’s just-deserts responsibility. Waller suggests that just-deserts responsibility causes physical, psychological and moral problems.⁷²

Waller rejects just-deserts responsibility as he believes it undermines take-charge responsibility, and is incompatible with medical science.⁷³ According to Waller, take-charge responsibility helps to better the individual. Without take-charge responsibility an alcoholic could not recover, as they need to take ownership of their choices, rather than blame others.⁷⁴ I disagree with Waller, as I believe that to hold people responsible, in the form of just-deserts responsibility, will encourage people to exercise more effective take-charge responsibility.

If people are held accountable for their lifestyle choices, then this cannot help but encourage people to effectively utilise take-charge responsibility. Consider an individual choosing to purchase health insurance under such a system. This individual will have to scrutinise all their vices and make decisions about which ones to insure. This individual might realise that spending extra money to insure against certain unhealthy habits is wasteful, and thus give them up. This enables the individual to exercise autonomy over their lifestyle choices.

⁷¹ Waller, Bruce N. (2005), Pg. 178

⁷² Waller, Bruce N. (2005), Pg. 178

⁷³ Waller, Bruce N. (2005), Pg. 183

⁷⁴ Waller, Bruce N. (2005), Pg. 180

Not only will such a system encourage close examination of behaviour, leading to take-charge responsibility, but it also leads to greater education. Individuals will be encouraged to seek out information about health care, and leading a healthier lifestyle. Armed with such information, individuals can decide how to best advance their own health care interests, and will feel a strong sense of control over their health decisions. In 2009, a series of advertisements screened on New Zealand television describing the journey of Adrian Pilkington, who was suffering from oral cancer resulting from years of heavy smoking.⁷⁵ He suggests that he knew lung cancer was a risk for smokers, but was not aware of other health complications associated with heavy smoking. Perhaps, if there had been a system of health care allocation based on just-deserts responsibility, Adrian would have sought out this information and saved his own life.

Waller suggests that this assumption, that just-deserts responsibility will encourage good behaviour, is incorrect. He demonstrates his idea through the comparison of two students.⁷⁶ Katrina is a bright student who achieves above average results, without expending very much effort. She is top of the class without operating at her maximum potential. Hanna, on the other hand, tries her best but receives only average results. While Katrina has no need to study, Hanna spends most of her free time in the library working hard. Katrina receives rewards, praise, and trophies for her minimal efforts, whereas Hannah receives nothing. Waller suggests that this Katrina's positive reinforcement will encourage her never to work to her full potential. Hanna on the other hand will become discouraged, as she will never achieve similar success.

⁷⁵ <http://www.stuff.co.nz/sunday-star-times/news/467767>. Date accessed 13th September, 2009.

⁷⁶ Waller, Bruce. N. (2005), Pg. 184

This example does not provide a strong objection to just-deserts responsibility in the context of healthcare. Therefore, I have reformulated the objection. Both Katrina and Hanna are heavy smokers. Katrina quits smoking, but Hanna is unable to and ends up contracting heart disease. Hanna is required to pay some of her medical expenses resulting from her personal choice to smoke. In this example, Katrina is not *praised* for her actions, or Hanna *punished*. Rather, Hanna is held accountable for her unhealthy behaviour. Therefore, the focus is not on the *praising* the healthy actions of Katrina but rather, ensuring that the unhealthy actions of Hanna do not harm third parties. The positive reinforcement from Waller's earlier example is absent. It is the outcome of unhealthy choices rather than *praise*, which modifies Hanna's behaviour. Such a system does not encourage Hanna to 'give up' and continue smoking, but rather avoid any bad consequences from her actions.

Waller suggests that another issue with just-deserts responsibility is that it promotes self-handicapping.⁷⁷ Self-handicapping refers to the mental belief 'if you cannot achieve something, why try?' Hanna may self-handicap herself by discontinuing to study, as she never achieves the same results as Katrina. I do not believe that just-deserts responsibility promotes self-handicapping any more than any other practice. If anything, it would discourage people from self-handicapping, as the consequences of not trying would be worse than trying and failing. To assign just-deserts responsibility is to give people a motivation that comes from an external rather than internal source.

⁷⁷ Waller, Bruce N. (2005), Pg. 185

Waller's objections have not raised serious problems for the theory, rather reinforced some of its foundations. There is still one objection, which I am yet to discuss. This objection, based on determinism, questioned whether individuals truly have control over their choices. I will account for this using John E. Roemer's 'Equality of Opportunity' theory (discussed in §6.2). Assigning just-deserts responsibility in healthcare helps to encourage the pursuit of a healthier lifestyle. Such policies will encourage take-charge responsibility. To hold an individual accountable for their actions is to encourage them to take control of their mistakes and address the problem. Just-deserts responsibility motivates individuals to take care of themselves, which can often be a challenge.

3.1.3 Practice makes perfect: Dien Ho and practical objections

Dien Ho objects mainly because he believes a system of health care resource allocation cannot work practically. He cites the comments of Carl Cohen, Martin Benjamin, and the Ethics and Social Impact Committee of Transplant and Healthy Policy Centre.⁷⁸ They outline what they consider the three main technical problems with allocating organs using moral responsibility considerations:

- 1) We have genuine and well-grounded doubts about the degrees of voluntariness, which shows that at this stage we cannot pass judgement fairly.
- 2) Even if we could assess the degree of voluntariness reliably, we cannot know which penalties different kinds of misconduct deserve.

⁷⁸ Ho, Dien (2008) 'When good organs go to bad people' *Bioethics* Vol. 22, Number 2, Pg. 80

- 3) Judgments of this kind could not be made consistently in our medical system.⁷⁹

These are legitimate concerns regarding applying the theory practically. Such objections do not show that the argument is false but rather emphasise the difficulty of practicing the system. Unfortunately, I am not trained in social policy, so I cannot respond to all these problems. However, I believe that, with a carefully crafted policy, these objections can be overcome.

The first complaint questions the validity of responsibility assessment. It is clear that responsibility varies in degree, but what is less clear is how to identify these degrees. The example of Roger Smith used in the first chapter showed that not only does information affect responsibility attribution, but also human emotion. However, it does seem possible to develop a system that can accurately account for moral responsibility. I will attempt to outline a possible system in the final chapter (§6.3).

The concern in number two is whether the consequences fit the crime, that is, what acts deserve which penalties. If there are different degrees of moral responsibility then this implies that the penalties should also vary, based on this degree. This problem could be significant in a situation where medical resources are so scarce not everyone can receive treatment. In the final chapter, a tool for assessing moral responsibility appears; the 'Responsibility Continuum'. When resources are so

⁷⁹ Ho, Dien (2008), Pg. 80

scarce and there is only enough treatment available for one, the individual placed closest to the 'Not Responsible' side of the continuum will receive treatment.

The third issue is one of practicality, but the problems with the practical application of the theory do not show that it has no moral worth. In fact, these objections have not shown that using moral responsibility as a criterion medical resource allocation is essentially *wrong*, but has highlighted some of the difficulties. The real issue of concern is whether moral responsibility *ought* to be a criterion for the allocation of medical resources.

Dien Ho believes that the moral responsibility argument reveals one of the fundamental conflicts in political philosophy; whether intentionally or not it discourages people from engaging on unhealthy practices.⁸⁰ He believes that this is at odds with liberal values that many of us cherish. New Zealanders have a history of accepting laws that are in our own best interests, an example is compulsory seatbelt use. However, there may be a problem with a more radical policy, especially if it affects the family purse. To penalise people for engaging in unhealthy behaviour, according to Ho, is at odds with the ideals that a liberal democracy represents. A liberal society allows the ability to engage in sub-optimal behaviours because freedom of choice is a human right.⁸¹

However, in response to Ho I would argue that to hold someone accountable for their actions does not infringe on their liberty. The agent may still engage in the behaviour, but they are subject to the consequences of that behaviour. Even in a

⁸⁰ Ho, Dien (2008), Pg. 82

⁸¹ Ho, Dien (2008), Pg. 82

liberal society, citizens are not able to do what they please. They must respect the rights of others. As such, the argument tries to prevent those who engage in sub-optimal behaviours from harming innocent third parties. The behaviour is still legal, but the agent will have to decide if the risk is worth the consequences.

Practical objections do not defeat the theory, so Ho's objections do not present a great challenge. However, he has noted some important considerations for implementing the theory as social policy. His final objection is that the policy is paternalistic. This worry, shared by Daniel Wikler, will be discussed in the next section.

3.2 Paternalism vs. coercive health promotion

'The 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 sufficient warrant.' - John Stuart Mill.⁸²

Daniel Wikler does not advocate using moral responsibility as a basis for medical resource allocation. He is particularly concerned that the policy is coercive and paternalistic.⁸³ However, paternalism only occurs when the policy is justified by appealing to the best interests of those engaging in unhealthy behaviour. Wikler sees this as the main justification, and therefore views it as a form of governmental coercion.

⁸² Gray, John (ed.) (1991) *John Stuart Mill: On Liberty and Other Essays* Oxford University Press : Great Britain : Oxford. Quote taken from *On Liberty*.

⁸³ Wikler, Daniel 'Personal responsibility for Illness' Pg. 336

Wikler suggests that coercive health policies are paternalistic, implemented for the citizen's benefit without their consent.⁸⁴ Wikler views this as a form of coercion. The Stanford Encyclopaedia of Philosophy defines paternalism as a state interfering with an individual, against their will, justified by a claim that it is for their own good.⁸⁵ This argument is used as a justification for health resource distribution based on merit. Whilst, I have not relied on this argument myself, I have chosen to present a defence of paternalism to show the policy is an example of justifiable paternalism.

In this section, the works of two authors are used to justify paternalism: Rosemary Carter and Simon Clarke. Carter argues that paternalism can only be justified with consent. Clarke argues that paternalism can be justified by an appeal to the neutrality constraint.⁸⁶ I will outline both views before Clarke's neutrality constraint is used to show that this type of paternalistic policy is justified.

3.2.1 Permitting paternalism

Donald VanDeVeer believes that the motives of the paternalist are not malicious, but stem from a desire to do the right thing.⁸⁷ However, one of the main problems raised with paternalism is that it violates the subject's ability to choose what they believe is best for them. This section opened with a quote from a famous defender of liberty, John Stuart Mill. He, and other libertarians, believed that

⁸⁴ Wikler, Daniel 'Personal Responsibility for Illness' Pg. 345

⁸⁵ <http://plato.stanford.edu/entries/paternalism/>. Date accessed 21st January, 2010.

⁸⁶ Clarke, Simon (2009) 'Principles of Paternalism' *Journal of Applied Ethics and Philosophy*, Vol. 1, September 2009

⁸⁷ VanDeVeer, Donald (1986), Pg. 17. See also; Clarke, Simon (2009) *Principles of Paternalism* 'Paternalism is the restriction of an individual's freedom for his or her own good.' Pg. 30

paternalistic intervention is only ever justified if it aims to prevent harm to others.⁸⁸ In this section, I will focus on Rosemary Carter's theory of consent, as justifying paternalism.

Rosemary Carter believes that there can never be a justified violation of an actual right. Therefore, a paternalistic act can only be justified if a person's *prima facie* right to non-interference, with respect to the relevant action, is not an actual right. As was mentioned in Chapter Two, a *prima facie* right is one which can be overridden when it is in competition with other rights. For example, in general we have a right not to have our limbs removed but if we had been in a severe car accident, and our survival depended on the removal of a limb, this right could be overridden by other competing rights.

There are three situations, according to Carter, in which overriding a *prima facie* right is permissible; the first, when a *prima facie* right competes with another more important *prima facie* right. The second, when its possessor alienates the *prima facie* right, and the third; when the realisation of the right would negatively affect others.⁸⁹ For Carter, the second condition justifies paternalism, or consent as she calls it.

According to Carter, there are two ways in which consent can be obtained from the subject, either prior to the paternalistic intervention, or subsequently.⁹⁰ Prior consent seems self-explanatory; the subject gives consent to the paternalist to

⁸⁸ Wolff, Jonathan (1996) *An Introduction to Political Philosophy* Oxford University Press : United States of America Pg. 112

⁸⁹ Carter, Rosemary (1977), Pg. 135

⁹⁰ Carter, Rosemary (1977), Pg. 135

interfere, usually if the subject acts in a certain way. For example, an obese person trying to lose weight, to be eligible for a gastric bypass operation, may request that their friend prevent them from purchasing unhealthy food. If the obese person tries to buy unhealthy food, their friend is justified in interfering and preventing the transaction. Regardless, of whether or not the person has changed their mind, their prior consent justifies the actions of the friend.

Subsequent consent occurs after the paternalism has taken place.⁹¹ This could occur if the friend of the obese person knew that they were trying to lose weight but had not been told to stop them from buying fatty food. The friend may choose to interfere anyway and prevent the person from purchasing unhealthy food, because they know that in the future they would have consented. The obese person may not appreciate the interference at the time, but may later thank the person for helping them. An expression of gratitude is a form of explicit consent for the previous action, thus justifying the intervention.

Prior consent to the receipt of health care resources conditional on moral responsibility, is a possibility. There are those, likely abusers of the system, who would argue against it. Subsequent consent may be given by the public by continuing to use the healthcare system, but this is problematic. Carter outlines six considerations that can be used when judging subsequent consent.⁹²

- 1) Is the paternalistic act in accordance with the permanent aims and preferences of the subject?
- 2) Is the subject in a temporary state of relative incompetence?

⁹¹ Subsequent consent is also referred to as future consent.

⁹² Carter, Rosemary (1977), Pg. 139

- 3) Does the subject lack the relevant information, which he will in the normal course of events come to possess?
- 4) Utilitarian considerations, that is, does the action create utility or disutility?
- 5) Does the action have harmful, irreversible consequences?
- 6) Do certain conventions obtain that may give rise to subsequent consent?

Given these conditions it appears that the policy, if it is paternalistic, can be approved using subsequent consent. The first condition is of particular relevance, as health is required to have aims and preferences. Therefore, if an agent has aims and preferences, then a policy targeted towards promoting good health will always be in accordance with the agent's preferences and aims. This idea relates to Rawls' account of primary goods, or goods that every rational man is presumed to want. Rawls' primary goods include; rights, liberties, and opportunities, and income and wealth. Health is deemed by Rawls to be a natural good, but without this natural good a man cannot desire primary goods.⁹³

Carter's consent theory provides some grounding on which to justify paternalistic intervention. However, Simon Clarke's neutrality constraint gives stronger grounds for paternalistic intervention. Clarke believes that in the absence of consent, the neutrality constraint should apply.⁹⁴

⁹³ Rawls, John (1971) *A Theory of Justice* (Revised Edition) Harvard University Press : United States of America Pg. 54

⁹⁴ Clarke, Simon (2009), Pg. 35

3.2.2 *Keeping it neutral: the good life*

Clarke's neutrality constraint justifies paternalistic intervention only when it is performed in a neutral manner, and not with the aim of directing the individual towards a particular conception of the good life.⁹⁵ To assign health care resources based on moral responsibility could violate this principle. It would seem that the government would be assigning resources only to those who conformed to the government's conception of a good life; namely, a healthy life. However, I argue that such a system still allows individuals to retain liberty and pursue their conception of the good life, but this may come at a cost. If Clarke's statement; '... the avoidance of death, is compatible with all conceptions of the good', is correct, then such paternalistic intervention in the area of health care is justified.

The system proposed aims to hold individuals accountable for their health states. This ensures that everyone receives a fair share of healthcare resources. Those who consume resources for self-inflicted conditions are unfairly draining the pool of resources, and this may disadvantage those who develop their conditions beyond their control. Dien Ho suggests that this health policy unfairly restricts liberties by *punishing* individuals for their involvement in sub-optimal activities.⁹⁶

Ho's assertion is incorrect; the system actually reinforces liberty. It does so by allowing people to more carefully scrutinise their lifestyle choices. This grants autonomy, and holding individuals accountable respects this autonomy. The system does not prevent individuals from engaging in unhealthy behaviour, but rather

⁹⁵ Clarke, Simon (2009), Pg. 30

⁹⁶ Ho, Dien (2008), Pg. 82

attempts to prevent their choices from causing others harm by unfairly consuming more resources than is fair. This ensures that all parties are able to pursue the lifestyles they wish, but with certain repercussions for those who choose riskier behaviours.

In this way, the proposed system actually helps individuals to avoid death. Clarke suggests that any paternalistic decision should be based on a neutral conception of the good life; however, without a life to live one cannot have a conception of the good. Any policy that actively promotes life is value-neutral. It does not force a particular conception of the good on anyone, as without some degree of health they cannot pursue their conceptions of a good life.

Clarke acknowledges that some individual's may have a conception of a good life that involves not preventing death. For someone to have such a conception, not due to false information or some sort of mental defect, would be extremely rare. In such cases, the healthcare system may not interfere. Their lifestyle choice is still compatible with resource allocation based on moral responsibility, as they are not consuming any resources whatsoever.

Clarke uses an example of a couch potato, and states that; 'forcing someone out of his couch potato lifestyle would be contrary to the paternalised's own conception of the good.'⁹⁷ However, the couch potato is someone who could cause themselves ill health by their behaviour, a potential target of the policy. By comparing

⁹⁷ Clarke, Simon (2009), Pg. 31

two couch potatoes, it can be proven that the policy fulfils the neutrality constraint, and is therefore justified.

Two couch potatoes, Brian and Andrew, live the same kind of lifestyle. They exercise minimally, work desk jobs, and spend their evenings in front of the television. They do not cook, and instead purchase most of their food from fast food outlets. Brian develops diabetes and heart disease resulting from his lifestyle. Andrew develops bowel cancer, which is unrelated to his lifestyle. There is only one bed available at the nearest hospital, funded by the men's local council.

If Brian got the bed, then Andrew would have to undergo costly treatment, and may not receive treatment at all. Therefore, Andrew could no longer fulfil his conception of the good life. Brian's unhealthy lifestyle has led to competition with Andrew for resources. Now, one may not receive treatment. Resources are scarce and there is only one free bed in the hospital. Without some degree of health care, neither Brian nor Andrew can fulfil their conceptions of the good life. Brian has unfairly denied Andrew the chance to live his conception of the good, whatever it may be. However, if Andrew received the bed, and Brian had to wait then he has not infringed on Andrew's conception of the good through his actions.

It may also be the case that only one bed was available because others, who had caused their ill health, were occupying the others. It seems probable that Brian would prefer that there were two beds available, rather than one. Brian's conception of the good life involves the healthcare system having enough resources to treat everyone, including himself. Therefore, it is conceivable that Brian would find a

system of healthcare resource allocation based on personal responsibility compatible with his conception of the good life. For not only does it allow Brian to live the lifestyle that he chose, but also helps to ensure that there are enough resources available for everyone. For it seems to be the case that Brian's conception of the good life involves receiving healthcare, so that he can continue to live his conception of the good life.

Paternalism seems like it could be justified in this particular case of resource allocation. In the absence of consent, an appeal to neutrality constraint has shown that certain instances of paternalism are justified. A system of resource allocation based on personal culpability is value-neutral as it still allows individuals to pursue their conception of the good life, and ensures that others may do the same.

3.3 Conclusion

The goal of this chapter was to outline some of the arguments against the moral responsibility argument, and try to provide some counter arguments. The focus has been particularly on the concerns of John Harris, Bruce Waller, Dien Ho, and Daniel Wikler.

First discussed were John Harris's views. Harris suggested that to punish people for their own adverse health is unjust. He believes that to suffer from sub-optimal health is punishment enough, and further punishment creates greater unfairness. To give people with self-caused medical problems lower priority is to punish them twice and, for Harris, this is unfair. I argue that it is more unfair for

innocent parties to suffer due to the actions of such individuals. Harris also regards emergency situations as a problem for the system, but triage principles should apply, with responsibility attributed at a later stage.

Next, I discussed Bruce Waller's objections. Bruce Waller objects on several grounds. In particular, he notes the distinction between just-deserts and take-charge responsibility. Waller believes that, while the goal of the system may be to encourage take-charge responsibility, it will actually discourage take-charge responsibility. He also believes that moral responsibility cannot be assigned, as individuals' behaviour is shaped by their circumstances. I have already refuted Waller's claims regarding take-charge responsibility, and the second objection will be accounted for in the final chapter.

Dien Ho also raised objections to the theory. Ho suggested that a system of health resource allocation based on moral responsibility could not work in practice. His reasons; it is too difficult to assign moral responsibility, to, and that society highly prizes the liberty associated with engaging in sub-optimal behaviours.

The first objection of Ho's did not present a strong challenge to the argument. A theory may seem unrealistic in practice, but this does not mean it has no moral worth. Ho's third objection is irrelevant. Individuals are still able to engage in these behaviours, but they come at a cost. This cost is restricted access to healthcare. Individuals must weigh up the whether the behaviour is more important than the risks, and if they think it is then they agree to the costs.

Daniel Wikler is particularly concerned about the issue of governmental coercion. He suggests that distribution of health resources based on merit is a policy of coercive health promotion, and is paternalistic. Coercive health policies are those with the intention of discouraging socially unpopular behaviours. Essentially, Wikler is concerned with the political implications of the theory and justifying it within that realm. This led to a discussion of paternalism.

Paternalism was discussed and then justified using the theories of Rosemary Carter and Simon Clarke. Carter believes that paternalism can be justified with consent; either prior or subsequent. Clarke argued that in the absence of explicit consent, paternalism can only be justified when the paternalistic act is neutral towards any conception of the good life. As demonstrated, a system of health resource allocation based on responsibility is compatible with a neutral conception of the good.

Overall, this chapter has dealt with some of the objections to the moral responsibility argument, and the majority object on practical grounds. Others question whether health resource allocation based on moral responsibility actually does create greater fairness, or if the goal of those who advocate the argument is just to *punish* people for socially unacceptable behaviour. Some suggested that such a policy is paternalistic and thus, paternalism required justification. The next section will focus on the 'restoration argument' as the strongest argument for the proposed policy.

Chapter Four: The ‘Restoration Argument’

4.0 Introduction

In the previous chapter some of the arguments for, and objections to, the moral responsibility argument were discussed. One argument for allocating medical resources based on moral merit that I am yet to discuss is the ‘restoration argument.’ A separate chapter is devoted to the ‘restoration argument’ because it represents one of the most persuasive arguments for the use of moral responsibility in resource allocation.

In this chapter, the ‘restoration argument’ is discussed in detail, beginning with the views of Brian Smart, and ending with a critique of Stephen Wilkinson. Smart identifies the principles behind the ‘restoration argument’ in his work, which is later criticised by Wilkinson. Smart believes moral responsibility should play a role in the allocation of resources as it helps to restore fairness. He likens the payment for medical treatment to reparations in civil law. The guilty parties are required to restore resources to those deprived through their actions.

4.1 Introducing the argument with Brian Smart

Essentially, the ‘restoration argument’ is focussed around the idea of restitution.⁹⁸ The main thrust is that those who are morally responsible for their injuries or illnesses are unfairly consuming more than their fair share of resources,

⁹⁸Restitution is defined as the act restoring something to its original state or a sum of money paid in compensation for loss or injury. wordnet.princeton.edu/perl/webwn. *Date accessed 15th February, 2010.*

and this results in innocent parties, potentially, receiving compromised care. The proposal is that those who consume more than their fair share should have to restore the resources to their previous state.

The 'restoration argument,' as defined by Stephen Wilkinson using smokers as a case study, follows thus:

- 1) Healthcare users can be divided into two groups: smokers and non-smokers.
- 2) Smokers are more likely to suffer from certain diseases than non-smokers.
- 3) This is widely known and there is a lot of information available regarding the risk of smoking and its side-effects
- 4) Therefore, from (2) and (3) smokers should know about the risks association with the habit, yet they still willingly and voluntarily subject themselves to this extra risk.
- 5) Because of (2), smokers are more likely to make demands on the health system than non-smokers. This is also widely known.
- 6) Therefore, according to (2),(3),(4) & (5), smokers knowingly increase their own health care needs.
- 7) Health care services are limited.
- 8) Given (7), if we don't reduce the health care entitlements of smokers, then non-smokers will be harmed by smokers as they reduce the chances of the non-smokers health care needs being met.
- 9) To allow non-smokers to be harmed by smokers is unfair

10) In order to avoid this unfairness the smokers health care entitlements should be reduced.⁹⁹

As the above argument outlines, the aim of the 'restoration argument' is to prevent the smokers from causing harm to the innocent non-smokers by depleting healthcare resources. If these people had not smoked then these resources would be available for others to use. Rather than aim to persuade the smokers to give up their habit, the argument intends to prevent their choices from affecting others in a negative way. The argument concludes that a way of preventing this harm would be to reduce smoker's health care entitlements.

Brian Smart, who suggests that in the case of priority access to health resources rectificatory justice should supplement distributive justice, introduces these ideas.¹⁰⁰ Smart is advocating a distribution of resources based on merit. If an individual unfairly consumes additional resources, due to their own personal responsibility, then they need to restore a fair distribution through restoration of resources.

Smart suggests that the above system of distributive justice is non-punitive as it is similar to the way reparation functions in civil law.¹⁰¹ As was mentioned above, ensuring distributive justice involves distributing resources to those who have a claim on them.¹⁰² However, when smokers use additional resources they create an

⁹⁹ Wilkinson, Stephen (1999) 'Smokers' Rights to Health Care: Why the 'Restoration Argument' is a moralising Wolf in a Liberal Sheep's Clothing' *Journal of Applied Philosophy* Vol. 16, No. 3 Pg. 256

¹⁰⁰ Smart, Brian (1994) 'Fault and the Allocation of Spare Organs' *Journal of Medical Ethics* Vol. 20, No. 1, March, Pg. 26. For further reading on rectificatory justice, please see Honore, A. M (1962) 'Social Justice' *McGill Law Journal* Issue 2, Number 8, Pg. 77 onwards.

¹⁰¹ Smart, Brian (1994), Pg. 26

¹⁰² For theories of distributive justice see; Rawls, John (1971) *A Theory of Justice*, Roemer, John E (1998) *Equality of Opportunity* and Nozick, Robert (1974) *Anarchy, State and Utopia*.

imbalance in the distribution, and it is no longer just. The smokers must relinquish an equal claim on the additional resources to restore distributive justice. The ‘restoration argument’ argues that smokers must have reduced entitlements in order to restore distributive justice. Thus, the smokers are required to pay reparations in the form of reduced access to health care.

The system of distributive justice I advocate is John E. Roemer’s ‘Equality of Opportunity.’ This theory is discussed in more detail in the final chapter (§ 6.2). The essential components involve dividing the population into different groups who share similar lifestyle and environmental factors. Within these, different lifestyle factors can be identified that dictate the entitlement to resources for each group. Any individual who uses more health care than was dedicated, and who has done so by exercising their personal choice, will restore the health care resource pool to its previous state.

One objection against the argument claims that introducing rectificatory justice turns resource allocation into punishment.¹⁰³ It is important to avoid such allegations of moral crusading. Justifications based on punishment are invalid because self-inflicted harm is not a crime.¹⁰⁴ I have already mentioned in the previous chapter (§ 3.1.1) that using the word ‘*punishment*’ is incorrect. Requiring an individual to pay a penalty for their preventable consumption of a good is not punishment, but rather a case of holding an individual accountable for their choice.

Smart’s justification for the ‘restoration argument’ is that a smoker’s sickness ceases only to affect them when they consume additional resources, which others may

¹⁰³ Smart, Brian (1994), Pg. 27

¹⁰⁴ Smart, Brian (1994), Pg. 27

have received had the smoker not made an unhealthy choice. If a smoker forfeits their equal entitlement to healthcare then their decision to smoke only affects them, rather than another innocent party.¹⁰⁵ Smokers can still choose to smoke, but they simply have to restore the resources which they have unfairly depleted in exchange.

The emphasis on ‘prevention of harm to third parties’ allows us to formulate an argument which is non-punitive. The smoker is not *punished*, but pays the costs of their risky behaviour. It is similar to the situation with motorcycle levies, mentioned in the introduction, the motorcyclists can still drive their vehicles, but they must pay the costs of the risky behaviour.

4.2 The so-called ‘Reverse Restoration Argument’

Stephen Wilkinson criticises the ‘restoration argument’ by applying it in reverse. Dubbed the ‘reverse restoration argument,’ it runs as follows:

- 1) Health service users fall into two groups: smokers, and non-smokers.
- 2) Non-smokers are less likely to suffer from life-shortening diseases.
- 3) (2) is widely known.
- 4) Therefore, from (2) and (3) non-smokers either should know about these health benefits that they are getting by not smoking, which means they are voluntarily lengthening their lives by choosing not to smoke.
- 5) Due to (2), non-smokers are likely to make more demands on the healthcare system because of their increased life span.

¹⁰⁵ Smart, Brian (1994), Pg. 27

- 6) Therefore, based on (2), (3), (4) & (5), non-smokers are knowingly increasing their own likely healthcare needs.
- 7) Healthcare resources are limited and there are no additional funds to meet these extra needs of the non-smokers.
- 8) If the healthcare entitlements of non-smokers are not reduced, then smokers will be harmed by the non-smokers. This is because non-smokers have increased the demand for healthcare by choosing not to smoke, and this decreases the chances of the smokers healthcare needs being met.
- 9) It is unfair to allow non-smokers to make smokers worse off.
- 10) In order to correct this imbalance, smokers healthcare needs should be prioritised.¹⁰⁶

If the 'reverse restoration argument' applies, then this identifies a major flaw in the logic of the 'restoration argument.' The 'restoration argument' tries to restore medical resources to those unfairly deprived of them by another group's comparatively higher requirements. The first argument assumed that smokers would require more medical resources than non-smokers would, but the 'reverse restoration argument' shows this assumption is incorrect. This means that if smokers do consume more medical resources than non-smokers do, the 'reverse restoration argument' fails as premise (5) no longer holds true.

¹⁰⁶ Wilkinson, Stephen (1999), Pg. 259

4.3 Wilkinson's criteria

To prove that the 'reverse restoration argument' is valid, Wilkinson proposes several possible ways to attack the argument. By refuting these attacks, Wilkinson intends to demonstrate its validity. He proposes three criteria: acts/omissions, self-harm, and social value. These criteria highlight the main differences between the behaviour of those who smoke, and those who do not. As such, they could outline a significant moral basis that justifies treating smokers and non-smokers differently, and shows why the 'reverse restoration argument' fails. Wilkinson ultimately rejects all the criteria. However, I argue that by combining self-harm and social value the 'reverse restoration argument' fails.

4.3.1 Acts vs. Omissions

The first is what he has dubbed the 'Acts/Omissions' criterion.¹⁰⁷ He suggests that there is a significant difference between the two arguments. The first concerns an act (smoking), and the second concerns an act of omission (not smoking). Perhaps, as Wilkinson suggests, it is only those who cause additional healthcare costs by their actions who should be punished.

In Chapter One (§1.3), it was suggested that, in the realm of health care, there is often no significant difference between acts and acts of omission. The example of someone who develops skin cancer from not applying sunscreen helps to illustrate this idea. This individual chose not to apply sunscreen before going outdoors, contrary to

¹⁰⁷ Wilkinson, Stephen (1999), Pg. 260

advice from their doctor. This person is just as much at fault for the development of their illness and the associated depletion of resources as the smoker, even though they have not acted to cause their disease but rather developed it from omitting to apply sunscreen. Thus, the Acts/Omissions criterion does not defeat the 'reverse restoration argument.' Wilkinson arrives at similar conclusions.¹⁰⁸

4.3.2 Self-Harm

The second criterion that Wilkinson proposes to defeat the 'reverse restoration argument' is the 'self-harm' criterion. This criterion notes the difference between those who consume additional resources by engaging in behaviour that is self-harmful, and those who consume additional resources without harming themselves. Wilkinson suggests that the 'restoration argument' may only be applied to those engaging in self-harmful actions¹⁰⁹ This means that the 'reverse restoration argument' does not apply to non-smokers as they are not harming themselves, whereas smokers are. Wilkinson ultimately rejects the self-harm criterion for a number of reasons.

His first reason is that the 'restoration argument' could potentially be used against those who work in dangerous occupations.¹¹⁰ Wilkinson is correct to note this problem of application. However, I believe that by combining the self-harm criterion, with another of Wilkinson's proposed criteria, this problem can be overcome, as I will discuss in the next section.

¹⁰⁸ '...and therefore that the acts/omissions criterion should be rejected' Wilkinson, Stephen (1999), Pg. 261

¹⁰⁹ Wilkinson, Stephen (1999), Pg. 261

¹¹⁰ Wilkinson, Stephen (1999), Pg. 262

Wilkinson argues against the self-harm criterion, because not only may apply it to those working in dangerous occupations, but also because he believes there is no significant difference between depleting resources through self-harmful behaviour, and depleting them in other ways.¹¹¹ Wilkinson's example is the hypothetical drug, *Agedelay*.¹¹² This drug can benefit 5% of the population by extending the life span of an *ordinarily healthy* person by 30 years, but it offers no protection against diseases. *Agedelay* users will still require healthcare, but for an artificially extended period making them more expensive citizens. Wilkinson claims that an argument for taxing *Agedelay* heavily could be made, to compensate for this additional cost. The additional tax is to cover the additional medical costs, that is, a restoration claim.

Not only do *Agedelay* recipients require additional resources they would not have needed had they not taken the drug, they also provide additional competition for organ transplants. In a situation, where an *Agedelay*-user is competing against a non-user for an organ transplant, the non-user may have a restoration claim, for it could be the case that the *Agedelay*-user would have died sooner rather than live to compete for the organ, if they not taken the drug. If they had died sooner then the non-user would have no competition for the organ. The non-user could claim that they are being harmed by the *Agedelay*-user's lifestyle choice, and thus should get the organ.¹¹³

Wilkinson suggests that the above example shows that self-harmful behaviours are not the only ones that are subject to restoration claims. He suggests *Agedelay* users are consuming more resources without engaging in behaviours that are self-harmful, and should still be subject to claims of restitution, as per the terms of the

¹¹¹ Wilkinson, Stephen (1999), Pg. 261

¹¹² Wilkinson, Stephen (1999), Pg. 262

¹¹³ Wilkinson, Stephen (1999), Pg. 263

‘restoration argument.’ If it is true that *Agedelay*-users are subject to restoration claims, then the ‘reverse restoration argument’ still stands.

However, I disagree with Wilkinson and believe that the self-harm criterion does give some basis for subjecting those, who get sick through self-harm, to restoration claims. The significant factor is social worth (Wilkinson’s third criterion). While the users of *Agedelay* may consume slightly more medical resources, they also make a positive contribution to society. Economically, they are involved in the work force for longer, helping stimulate the economy. They may also perform socially useful occupations, such as; police work, fire fighting, and so on. Some will become grandparents and have a positive influence in their grandchildren’s lives. If their children die, they may become guardians. Those that no longer work will be able to contribute to community organisations and charity groups. Thus, while *Agedelay* users will consume more resources by virtue of the fact that they live longer, they will also generate more revenue and make positive contributions to society.

As for organ transplants, an *Agedelay* user may get more life years out of the same organ than a non-user.¹¹⁴ The average lifespan in New Zealand for 2000 was seventy-seven point eight years.¹¹⁵ If the potential non-*Agedelay* organ recipient was fifty years old, and the *Agedelay* recipient was eighty years old, then both would have the same predicted outcome of years. If the non-user was older than fifty then the *Agedelay*-user would live longer if they received the organ, and therefore get more

¹¹⁴ The following argument relies on similar considerations to that of QALY’s (Quality Adjusted Life Years). QALY’s were introduced in 1980’s, by economists, as a way of measuring the cost-effectiveness of medical treatments. For further reading see Glannon, Walter (2005) *Biomedical Ethics* Oxford University Press, Inc. : United States of America Pg. 149-152, and Harris, J. (1987) ‘QALYfying the Value of Life’ *Journal of Medical Ethics* Vol. 13, Number 3, September.

¹¹⁵ <http://geography.about.com/library/weekly/aa042000b.htm>. Date accessed 24th September 2009.

use out of the organ. If the non-user was younger than fifty, they are more likely to receive the organ given their level of functionality, and probability of a successful operation. If the *Agedelay* user would get more use out of the organ, this gives them a stronger claim. If this is so, then the relevant factor is not whether or not the individual used *Agedelay*, but the positive outcome for the patient. It is true that the non-user would have had a one hundred percent chance of receiving the organ, but the user may actually benefit more. Therefore, the *Agedelay* user should not be subject to reduced entitlement because of taking the drug.

Agedelay also only affects a very small number of the population, so the additional resources used are not as great as those used by people, who have gotten sick through self-harm. This shows that *Agedelay* users should be immune from restoration claims, as their positive contribution to society outweighs the cost of the medical resources. Actions that are not self-harmful should be immune from restoration claims, but I believe that something more is required in order to strengthen their claim for resources. When an action is not self-harmful, and has social value, then it is no longer subject to restoration claims. Social value will be discussed later in this chapter.

Wilkinson uses another example to emphasise his claim that there is no moral difference between using additional resources through self-harmful, or non-self-harmful actions. The additional example is procreation. To bear children carries not only a risk to the mother's health, but also an additional burden on medical resource. However, bearing children is considered a self-harmful behaviour. Wilkinson

suggests that non-parents may have a legitimate restoration claim against parents as they are unfairly consuming resources in order to procreate.¹¹⁶

I would argue that to punish parents for bearing children is counter-productive to society. To promote a policy which effectively discourages parents from bearing children is sheer madness. Without procreation, society cannot continue and would eventually die out. This argument appeals to the social value of parenting. Thus, the social value in parenting far outweighs any restoration claim that might be made.

Essentially, my defence of both the examples has relied on the final criterion analysed by Wilkinson; social value. So far, the acts/omissions criterion has been examined, and the self-harm criterion. Immediately rejected was the acts/omissions criterion, as I cannot see a significant moral difference between actions that cause ill health. Intentional omissions amount to the same thing.

The self-harm criterion was examined and Wilkinson suggested that there is no difference between depleting resources through self-harmful actions, and depleting them in other ways. His examples included; the users of a hypothetical drug, *Agedelay*, and potential parents. Wilkinson's *Agedelay* example did not show that the self-harm criterion fails. Instead, I suggest that it needs strengthening. By combining the social value and self-harm criteria, a significant moral difference between smokers and non-smokers can be identified.

4.3.3 Social Value

¹¹⁶ Wilkinson, Stephen (1999), Pg. 263

The last criterion proposed by Wilkinson suggests that the ‘restoration argument’ only applies to those practices that do not have significant social value.¹¹⁷ Discussed in this section are Brian Smart’s ideas of social value, and Wilkinson’s critique of the criterion. Ultimately, when a practice has no discernible social value and causes the user harm, it is subject to restoration claims. The argument has implications for those engaging in harmful, but socially useful, occupations, as well as sportsmen.

One problem with allocating healthcare resources based on moral responsibility is that many individuals freely choose to put themselves at risk for their occupation. They choose a certain lifestyle that may put their health in danger, without being forced. An example is the police force. The moral responsibility argument needs to address why those with socially valuable occupations should be immune from claims of restitution. They are immune because they have significant social value, that is, the social value criterion.

Socially valuable occupations are those important to society. In other words, society would suffer negatively if there were no one to perform that task. To subject these individuals to restoration claims will only discourage them from pursuing necessary careers, and this would be detrimental to society. Therefore, I argue that those with socially valuable occupations should not be subject to restoration claims.

The previous discussion identifies a problem of scope with the social value criterion. For example, sports may have social value, but do not contribute to society

¹¹⁷ Wilkinson, Stephen (1999), Pg. 263

as a whole. Rock climbing is a prime example of a dangerous sport that can cause serious injuries. To treat these injuries, the resources used could be considered *additional*, as the individual would not have required them without engaging in the sport. On the other hand, rock climbing is a sport that keeps individuals fit. Those who engage in rock climbing on a regular basis also gain skills, which could be useful in emergencies. As Smart points out, sports have intrinsic and extrinsic value. Intrinsically, skills of a high order can be obtained and extrinsically, the sports are character forming which helps contribute to a worthwhile life.¹¹⁸

I believe that sports should be immune from restoration claims provided their practitioners conform to all safety guidelines. If a rock climber has taken all the precautions possible to ensure a safe climb and they have an accident, they will not be responsible for the resultant healthcare costs. Conversely, those who do not take the recommended safety precautions and who become injured, should be subject to restoration claims.

This argument may seem odd given the assertion within the thesis that to risk one's health is to risk your right to healthcare. However, subjecting people who play sports safely to restoration claims, contradicts the aim of this project. To discourage people from engaging in exercise would create a new group of patients with easily preventable illnesses, obesity. This has the potential to be even more taxing on the healthcare system, especially if they require gastric bypass surgery (which can cost between nineteen thousand and twenty-five thousand dollars privately).¹¹⁹ Regular

¹¹⁸ Smart, Brian (1994), Pg. 29

¹¹⁹ <http://www.novamedical.co.nz/procedures/bariatric-obesity-surgery/gastric-bypass-roux-en-y-/>.
Date accessed 11th February, 2010.

exercise has known health benefits, but there are going to be some sports which even when practiced according to safety guidelines still carry a large amount of risk.¹²⁰

Some sports, such as B.A.S.E (Building, Antenna, Span, Earth) jumping, should always be subject to restoration claims. BASE jumping is like skydiving, but jumpers launch themselves off inanimate objects such as buildings, antennas, bridges and cliffs. There is only a short time to open the parachute, and no reserve chute is used.¹²¹ A study has found that 'BASE jumping is associated with a high risk of serious injury and appears to be significantly more dangerous than skydiving.'¹²² Some sports will be associated with too great a risk, and if individuals want to practice them and receive medical treatment they will need to purchase insurance.

Wilkinson objects to the social value criterion because social value could become a case of what behaviour society currently approves and disapproves.¹²³ Wilkinson uses the example of homosexuality to illustrate this point. Wilkinson claims that the homosexuality generates similar additional costs to childbirth, and that the majority could value one practice over the other. He suggests that practices will be judged for their social value based on popular opinion rather than facts.

Wilkinson is incorrect to identify the costs of HIV as the costs of male homosexuality. HIV occurs in both hetero and homosexual couplings. It is in fact the

¹²⁰ Benefits include living longer, preventing diabetes, maintaining a healthy weight, preventing cancer and heart disease, reducing the risk of high blood pressure and colon cancer, helping with psychological well-being, building and maintaining healthy bones and joints, and individuals overall happiness. See <http://www.nlm.nih.gov/medlineplus/exerciseandphysicalfitness.html> and <http://www.nutristrategy.com/health.htm> for more information. *Date both accessed 24th September, 2009.*

¹²¹ http://en.wikipedia.org/wiki/BASE_jumping. *Date accessed 11th February, 2010.*

¹²² Monasterio, Erik and Mei-Dan, Omer (2008) 'Risk and Severity of injury in a population of BASE jumpers' *Journal of the New Zealand Medical Association* Vol. 121, Number 1277, July

¹²³ Wilkinson, Stephen (1999), Pg. 264

practice of unsafe sex, which carries the risk, rather than homosexuality. Unsafe sex involves not using any form of contraception or protection to prevent the transmission of STI's and HIV. Unsafe sex is a practice for which an individual is morally responsible. It can cause the practitioner harm through the potential contraction of diseases, satisfying the self-harm criterion discussed earlier. Unsafe sex also does not have the social value. Unsafe sex is distinct from unprotected sex. Sexual intercourse practiced without contraception, when both partners have been tested for any form of STI, is unprotected sex. Unsafe sex should be subject to restoration claims as it can create significant health care costs.

The other problem, besides Wilkinson's confusion of homosexuality with HIIV, is that his assertion is incorrect. Annually, the cost of childbirth and HIV are not similar. In 2004, 55,213 live babies were born in New Zealand. According to a report by the Agency for Healthcare, Research and Quality, the costs per uncomplicated pregnancy and hospital birth averaged to be about seven thousand and six hundred dollars in 2004.¹²⁴ Multiplying the number of babies born by the figure given for an *uncomplicated* pregnancy (complicated pregnancies would presumably generate larger costs) the total health care spending is \$149,618,800, nearly one hundred and fifty million. In 2004, it was estimated that there were between one thousand and two thousand and one hundred people living with HIV in New Zealand.¹²⁵ It is hard to find a clear yearly cost average cost for HIV treatment, but one source suggested that it was about ten thousand dollars per year.¹²⁶ Assuming this is the case then the yearly

¹²⁴ http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR-ID=48370. *Date accessed 23rd September, 2009.*

¹²⁵ Data.unaids.org/pub/.../2008/20080818_gr08_plwh_1990_2007_en.xls. *Date accessed 10th February, 2010.*

¹²⁶ <http://www.auckanglican.org.nz/?sid=298>. *Date accessed 23rd September, 2009.* This is a statistic for New Zealand specifically. In America it is suggested that every Aids patient who lives for about 24

cost for HIV in 2004 would have been approximately twenty-one million dollars (using the highest estimate). There is a significant difference between the yearly birthing costs and the costs for HIV. Thus, Wilkinson's claim, that HIV patients and mothers giving birth generate similar healthcare costs, is false.

Wilkinson suggests that we should reject the social value criterion because it could be based on what society happens to currently accept. As mentioned above, the examples Wilkinson uses do not refute the argument as such. However, this is still an objection to the theory. It does seem possible that a 'tyranny of the majority' situation could occur. To escape this objection, the social value criterion and the self-harm criterion should be combined. For a practice to be subject to restoration claims, it must; a) cause the practitioner medical harm and, b) have no obvious social value. This ensures that the public does not attack practices, which are socially unpopular.

4.3.4 Does social value invite a moral crusade?

If we are to include social value in the evaluation of moral culpability then, Wilkinson suggests, the argument has now lost one of its most attractive features; being non-punitive.¹²⁷ Anyone with a lifestyle deemed socially invaluable is penalised. However, as previously stated (§ 3.1.1) punishment is the wrong word. Rather, to hold someone morally accountable is to treat them as a moral agent. It is a choice to engage in this behaviour, not a necessity. If an individual is acting with complete knowledge of the consequences, it is fair to hold them morally accountable.

years will cost more than \$600,000 with the average annual cost being about \$25,200
<http://www.msn.bc.msn.com/id/15655278>. Date accessed 23rd September, 2009.

¹²⁷ Wilkinson, Stephen (1999), Pg. 266

They have traded-off one preference for another; they wish to smoke, and so accept that they must give up some entitlements to healthcare (or that healthcare will come at a greater cost).

Wilkinson disagrees with the evaluation of lifestyle choices required to make this kind of judgment.¹²⁸ However, I question whether this is really happening. Surely, a list of social practices immune, and subject to, restoration claims could be prepared to which members of the public have free access. Anyone can become aware in advance of those lifestyle choices that require the user to pay restitution.

Wilkinson quibbles with the idea of social value because he believes that it is not morally neutral. However, it is Wilkinson who frames the argument in morally bias terms and becomes the ‘moralising wolf’ he claims the ‘restoration argument’ to be.¹²⁹ His suggestion that controversial practices could be subject to restoration claims, such as homosexuality, is a poor example that fails to focus on the facts. It is not the practice of male homosexuality, which is instrumental in the transmission of HIV, but unsafe sex. This applies to all engaging in sexual intercourse, not just those who prefer same-sex companionship.

The ‘restoration argument’ can make morally objective lifestyle evaluations by combining two of Wilkinson’s criteria. For example, male homosexuality may not be seen as socially valuable by some, but it cannot be proven that homosexuality in itself is self-harmful. Therefore, the practice is immune to restoration claims. If a practice is proven to have no social value and harms the practitioner then a restoration claim can

¹²⁸ Wilkinson, Stephen (1999), Pg. 266

¹²⁹ Wilkinson, Stephen (1999), Pg. 266

be fairly made. This is an objective evaluation of a lifestyle choice, where moral approval is not a factor.

Wilkinson has raised some fair objections to the ‘restoration argument,’ introduced by Brian Smart. However, rather than refuting the argument, Wilkinson has instead come up with two criteria that help to strengthen the argument; the social value and self-harm criterion. In order for an action to be subjected to restoration claims, it must not only have no social value but also cause the practitioner harm and through this harm to third parties also.

4.4 Conclusion

Within this chapter two important views have been discussed; particularly those of Brian Smart and Stephen Wilkinson. Smart suggested the basic concepts of the ‘restoration argument.’ Smart’s belief is that those who unfairly consume resources, that is, use more than their fair share, should restore damages to those who miss out due to their unfair usage. The aim is to prevent any harm to third parties which could be caused by these less ‘innocent’ members of society.

Wilkinson raised several objections to the ‘restoration argument’ by suggesting that, if we reversed the argument, it shows that smokers have a legitimate restoration claim against non-smokers. If the ‘reverse restoration argument’ holds true then there is no reason to favour one group over another, for both have legitimate restoration claims. For the ‘restoration argument’ to work, the ‘reverse restoration argument’

needs falsification. Wilkinson suggested several criteria by which to do this; acts/omissions, self-harm, and the social value.

Previous discussion already rejects the acts/omissions criteria (see chapter one, §1.2), because a person can be held equally at fault for their actions as their omissions. The example of the patient who refuses to apply sunscreen their entire life and then develops skin cancer illustrated this idea. Thus, depending on the consequences, moral responsibility applies to actions and omissions.

The other two criteria mentioned by Wilkinson are self-harm, and social value (already mentioned by Brian Smart). Wilkinson rejects both, but they present a stronger objection to the ‘reverse restoration argument’ when they are combined. Wilkinson rejects the self-harm criterion because he sees no significant difference between self-harmful actions that deplete resources, and other actions. Wilkinson used the example of *Agedelay*, and suggests that those who do not take *Agedelay* could have legitimate restoration claims against those that do.

Taking into account social worth changes the situation. Whilst *Agedelay* users may consume more resources by living longer, there are also other factors to consider like their contribution to society both economically, and socially. Therefore, there is a significant difference between actions that are self-harmful, and those that are not, when we take into account the social value generated by the non-self-harmful actions. It is very difficult to demonstrate that self-harmful actions have social value.

Wilkinson seeks to reject the social value criterion because, according to him, this makes the 'restoration argument' punitive. To Wilkinson, the evaluation of lifestyle choices required to assess social value is an attempt to punish people for their actions. However, combining the self-harm and social value criteria avoids allegations of moral crusading. Many actions are socially invaluable, or thought to be so by the general public, but unless they are self-harmful they are not subject to claims of restitution.

Whilst Wilkinson has raised some interesting objections to the 'restoration argument,' he himself admits that these do not defeat the argument decisively.¹³⁰ I have shown that the 'reverse restoration argument' does not defeat the 'restoration argument.' Therefore, the 'restoration argument' is a strong justification for allocating medical resources based on moral responsibility.

Smart makes one final recommendation in his paper; that a system of resource allocation based on moral responsibility would only be just within 'a robust framework of preventative medicine, meaning effective health education, and the elimination of cigarette advertising.'¹³¹ One problem with the example of cigarettes is that they contain an addictive substance: nicotine. Addicts are a problem case for the theory, as it is unclear to what degree addiction should diminish responsibility. Discussion of these issues takes place in the following chapter.

¹³⁰ Wilkinson, Stephen (1999), Pg. 266

¹³¹ Smart, Brian (1994), Pg. 30

Chapter Five: The problem of ‘addiction’

‘Drug addiction is unbounded by geography, form of government, politics, ethnicity, economic-status, or degree of formal education. In other words, it is a problem of the human condition.’¹³² - Avram Goldstein, M.D.

5.0 Introduction

Recently, coverage of a trial for vehicular manslaughter aired on New Zealand television. Alison Downer, 71, now faces two years and two months jail time for causing the death of cyclist, Frank Van Kampen. Downer’s breath test revealed she had nearly twice the legal limit of alcohol per litre of breath. The charge of vehicular manslaughter is her fourth drink driving conviction.¹³³

The maximum penalty for manslaughter in New Zealand is life imprisonment, but Downer received two years.¹³⁴ Why was her sentence closer to the minimum than the maximum? She is an alcoholic, who has also been taking anti-depressants for several years. Her addiction, and her offer to pay \$30,000 damages, resulted in diminished responsibility for the crime. This instance of sentencing implies that society believes that addiction can impair judgment, especially judgments of right and wrong.

¹³² Goldstein, Avram (1994) *Addiction: From Biology to Drug Policy* W. H Freeman and Company : United States of America Pg. 237

¹³³ <http://www.stuff.co.nz/national/crime/3290328/Drunk-grandma-jailed-for-mans-death>. Date accessed 15th February, 2010.

¹³⁴ <http://www.courtsofnz.govt.nz/about/system/role/sentencing.html>. Date accessed 15th February, 2010.

In the next chapter, I will focus on precisely this issue. The problem; many addicts voluntarily *choose* to take their substance of choice initially, but seemingly have no control over their actions once they become addicted. They can cause great damage to their health by engaging in addictive behaviour, which is quite possibly involuntary. If it is true that the action is involuntary then it is not fair to hold them morally responsible. The main concern within this section; to what degree does addiction diminish moral responsibility.

The following discussion will show that addiction is a highly complex area of research. It is difficult to come to any overriding conclusion as to whether addiction is beyond the sufferer's control. However, I will argue that addiction to legal substances accounts for a greater degree of diminished responsibility, than addiction to illegal ones. Therefore, alcoholics, food, nicotine, and all other addicts, addicted to legal substances, are less accountable than those addicted to illegal drugs are. This is because addictions to illegal drugs are, generally, harder to maintain. I will also argue that addicts who seek help are subject to a greater degree of diminished responsibility than those who do not.

5.1 Addiction Theories

Addiction causes a problem for moral responsibility. There is a question over whether addiction minimises or absolves the addict from responsibility, or whether it renders the agent equally responsible to the non-addicted. In this section, I will give an overview of some addiction theories. These demonstrate that continuing to take the addictive substance can be a rational choice for the addicted. They also show that it is

precisely the individuals who underestimate their susceptibility to addiction, who are most likely to become addicts. Finally, genes may play a role in dictating who becomes addicted.

5.1.1 Addiction: the rational choice?

Chrisoula Andreou suggests one of the problems with addiction is that, for an addict, using their drug of choice can be the rational course of action.¹³⁵ She uses an example called, the ‘self-torturer.’¹³⁶ The self-torturer is hooked up to a portable machine, capable of administering electric shocks at the strength of one to one thousand. The self-torturer, taking part in a medical experiment, will be paid \$10,000 for each successive level of shock they administer themselves. Once they have shocked themselves at level one, however, they cannot return to zero. The self-torturer is likely to prefer to stop at one than at zero, but not likely to want to continue to one thousand.¹³⁷

It may be easier to illustrate the self-torturer’s predicament with reference to a more practical application of the example. A cocaine addict may be aware that taking a second hit of cocaine could lead to health complications, however, the agent may reasonably believe that taking only one more hit of cocaine will not lead to bad health in itself. They also know that taking a hit will mean avoiding potential withdrawal

¹³⁵ Andreou, Chrisoula (2005) ‘Going from Bad (or Not So Bad) to Worse: On Harmful Addictions and Habits’ *American Philosophical Quarterly*, Vol. 42, No. 4, October Pp 323-331

¹³⁶ This example originally appears in Quinn, Warren (1993) ‘The puzzle of the self-torturer’ *Morality and Action* Cambridge University Press, United States of America

¹³⁷ Andreou, Chrisoula (2005), Pg. 326

symptoms.¹³⁸ Thus, they prefer taking the cocaine, than not taking it. However, they do not prefer to keep taking the drug indefinitely.

Thus, the addict's main problem, according to Andreou; that taking one more pill, having one more cigarette, or consuming one more drink may not directly lead ill health and, in fact it will often lead to a good outcome for the addict. Particularly, if they are suffering from withdrawal symptoms. Therefore, the agent's consumption of their drug of choice is not only what they desire, but it is rational for the addict. Given this information, holding an addict responsible for their behaviour is to hold them accountable for a rational choice.

However, this choice is only rational once they have become addicted to the substance, as having 'one more' alleviates the symptoms of withdrawal. Therefore, if addicts are accountable then perhaps their accountability lies in the origin of their addiction.

5.1.2 Visceral factors and their effects on behaviour

George Lowenstein offers, what he calls, a visceral account of addiction.¹³⁹

Visceral factors include drive states such as hunger, thirst, sexual desire, moods,

¹³⁸ There was a belief that cocaine was not addictive as it does not produce obvious withdrawal symptoms. However, cocaine withdrawal is associated with depression, anxiety, agitation, suspiciousness and paranoia. With continued abstinence an addict may experience extreme boredom, lack of motivation, and depression. These symptoms could be alleviated with another dose. Cocaine addicts are extremely vulnerable to relapse. Goldstein, Avram (1994), Pg. 161

¹³⁹ See Lowenstein, George (1999) 'A Visceral Account of Addiction' in *Getting Hooked: Rationality and Addiction* Edited by Jon Elster and Ole-Jørgen Skog : Cambridge University Press : United States of America. I have presented Lowenstein's account as it suggests a high possibility of an addict to relapse. As Olav Gjelsvik remarks in his paper 'Addiction, Weakness of the Will and Relapse' (from *Getting Hooked: Rationality and Addiction*) 'an account of addiction that makes relapse after quitting very unlikely is *a priori* unacceptable as an account of addiction' Pg. 56

emotions and physical pain.¹⁴⁰ These overwhelm the agent, and contribute to making the desire for their drug of choice almost irresistible. Lowenstein suggests that almost everyone underestimates their ability to overcome such factors, which is why so many people become addicts.¹⁴¹ This shows that individuals are often not capable of knowing initially whether they may act uncontrollably at a later stage. Avram Goldstein's research also supports this conclusion. Speaking with heroin addicts showed that many in the first instance took heroin out of curiosity believing that although others might become addicted, they would not.¹⁴²

Loewenstein's research suggests that anyone indulging in an addictive substance is a candidate for diminished responsibility. It also suggests that people are not capable of determining that they may become addicted at a later stage, as they overestimate their ability to resist cravings. It is precisely the people, who underestimate their susceptibility to cravings, who are likely to become addicts. Even if we consider that a large amount of information is available to the public about the addictiveness of certain substances, some individuals may still think themselves capable of trying a drug without becoming addicted.

5.1.3 An addictive personality

Genetic factors add a further complication to the addiction puzzle. Avram Goldstein suggests that denying a role for genetics in an account of addiction 'only

¹⁴⁰ Lowenstein, George (1999), Pg. 235

¹⁴¹ Lowenstein, George (1999), Pg. 240-2

¹⁴² Goldstein, Avram (1994), Pg. 140

begs the question.’¹⁴³ He specifically discusses the genetic factors associated with alcoholism. These have been identified in a number of ways. One is through the intolerance that certain cultures have to alcohol, known as the ‘oriental flush.’ About half of all people from Chinese and Japanese descent experience an adverse reaction to alcohol. Caused by a gene mutation; they experience severe headaches, a facial flush, and other more serious reactions can occur.¹⁴⁴ If a genetic mutation can be responsible for an adverse reaction to alcohol then there is a chance that genes could be responsible for a genetic predisposition towards addiction.

C.R Cloninger has produced some interesting findings relating to the link between genes and alcoholism.¹⁴⁵ He found that the sons of alcoholics adopted into families of non-alcoholics had a four-fold greater chance of becoming alcoholics than their adoptive brothers. The sons of non-alcoholic parents who were adopted into alcoholic families conversely did not tend to become alcoholics. This shows that genetics can often be an overriding factor in the development of alcoholism rather than environment.¹⁴⁶

If there is a genetic predisposition towards alcoholism then this has an affect on responsibility for addiction. It certainly grants diminished responsibility. But should it absolve responsibility completely? This question is very difficult to answer. An alcoholic cannot become an alcoholic without taking a drink, or regularly engaging in binge drinking. However, in New Zealand there is a prevalent drinking

¹⁴³ Goldstein, Avram (1994), Pg. 90

¹⁴⁴ Goldstein, Avram (1994), Pg. 93

¹⁴⁵ Goldstein, Avram (1994), Pg. 94

¹⁴⁶ Goldstein, Avram (1994), Pg. 94

culture.¹⁴⁷ Alcohol is present at most social occasions. If Lowenstein is correct, and we underestimate our ability to resist the visceral factors, and overestimate our abilities to resist addictive substances, then it is unlikely that individuals consider potential alcoholism when drinking socially. Therefore, it seems that if an agent was unaware of a genetic predisposition to alcoholism, and chose to drink at a social occasion in New Zealand, then they are less responsible due to the general acceptance and tolerance of drunken behaviour by New Zealanders.

Two issues arise from the previous statement; first, whether or not an individual who knows they could have a predisposition should refrain from drinking in social situations and, second, whether or not New Zealand should control alcohol consumption more strictly. These issues are intertwined; for as long as alcohol is accepted by society then it seems as though people are less responsible for addictions that develop from socially acceptable behaviour. If alcohol became less socially accepted then they may be held to a greater degree of responsibility.

5.1.4 The relationship between addiction and responsibility

However, whilst genetics can explain some addictions, it cannot explain all addictions. Not all addictions result from genetic factors, so whilst Lowenstein may be correct that individuals can underestimate their ability to resist future cravings, it remains a fact that not all individuals become addicts. For example, many people do not take heroin because it is a dangerous drug. Whilst they may also believe that they could take heroin once and not become addicted, this belief has not lead to an

¹⁴⁷ See http://www.scopp.co.nz/stories/GE0511/S50006_0.htm, <http://www.alcohol.org.nz/media/release.aspx?PostingID=821>, and <http://www.theepochtimes.com/n2/content/view/20531>. *Date accessed 7th December, 2009.*

indulgence in the substance. It seems that personality can affect an individual's susceptibility to addiction, as some people are more inclined to engage in risky behaviours.¹⁴⁸

Assessing what degree addicts are morally responsible for their ill health is not a straightforward matter. Lowenstein would perhaps suggest that addicts are only morally responsible to a small degree, given the evidence that individuals underestimate their susceptibility to cravings, and addiction. Goldstein states that all addicts are morally responsible for their criminal behaviour, but he would probably only advocate holding them morally responsible for their health states if the addict benefitted.¹⁴⁹ Gary Watson suggests that, according to the law, addicts could mount a defence for criminal behaviour based on duress caused by the addiction. He believes that the cravings experienced by addicts can mean that they are unable to act lawfully.¹⁵⁰ Watson also favours diminished responsibility.

As shown, there appears to be no general agreement between the authors as to whether or not addicts can control their behaviour. It seems, on the surface, fair to hold people responsible for their initial decision to take illegal substances that lead to addictions. Furthermore, it is clear that not everyone underestimates their ability to resist visceral factors, for not everyone is an addict. However, Lowenstein's research suggests that it is those, who underestimate the visceral factors, who are more susceptible to addiction. The reasons why these people, and not others, overestimate

¹⁴⁸ See Cloninger, C. Robert, Sigvardsson, Sören and Bohman, Michael (2006) 'Childhood personality predicts alcohol abuse in young adults' *Alcoholism: Clinical and Experimental Research* Vol. 12, Issue 4, April, pp 494-505

¹⁴⁹ Goldstein, Avram (1994), Pg. 227

¹⁵⁰ Watson, Gary (1999) 'Addiction and Responsibility' in *Law and Philosophy*, Vol. 18, Number 6, November, Pg. 605

their abilities to resist visceral factors significantly effects moral responsibility. If this mechanism is their own creation then it seems reasonable to hold them fully responsible, but if it is something which they have no control over, then they are less responsible.

It is very difficult to come to any overriding conclusion regarding responsibility. Perhaps there is a case for stronger alcohol regulations, and regulations for other addictive substances. These could include making alcohol more difficult to obtain by raising the legal purchasing age. However, what is clear is that addicts can deprive non-addicts of medical resources if ill health develops from their addiction. Addicts fall under Harris's double jeopardy objection (§ 3.1.1) as they would be suffering twice – firstly, by going through the harrowing experience of addiction and second, by suffering from ill health resulting from their addiction.

To ascertain degrees of responsibility for addictions, Moss and Siegler provide an intriguing account. They suggest that alcoholics can be held responsible, not for their addiction, but for their decision not to seek treatment. Therefore, an alcoholic who tries to obtain treatment for their addiction will be held less responsible (if responsible at all) for their alcohol-related diseases, than one who does not. Moss and Siegler justify this approach on the grounds that accepting responsibility plays a key role in an alcoholic's recovery.¹⁵¹

This should apply to all addicts provided there are free treatment programs available to them. An addict who accepts they are addicted, and knows that their

¹⁵¹ Moss, Alvin and Siegler, Mark (2006) 'Should alcoholics compete equally for liver transplantation?' from Kuhse, Helga and Singer, Peter (Eds) *Bioethics: An Anthology (2nd Edition)* Blackwell Publishing Ltd. : United Kingdom Pg. 423

addiction could lead to health complications, is complicit in their addiction if they do not seek help. For, if they do not, they become responsible for their continued addiction and ought to be held accountable. Addicts who seek help should receive diminished responsibility.

5.2 Alcoholics: a case study of addiction

In discussion on the topic of moral responsibility and healthcare, an interesting problem is raised. Namely, that many of the habits these policies target are classed as addictions. Smoking and drinking are the two vices receiving the most discussion. We view them as unnecessary and avoidable.¹⁵² This section will be primarily concerned with the alcoholism. I will focus on some of the key issues in relation to alcoholism, and their effects on responsibility. I argue that alcoholics and nicotine addicts are less responsible than those addicted to illegal substances, and those who try to seek help even less responsible.

5.2.1 The first drink

In the previous section, there are several theories, pertaining to addiction, presented. These include; Andreou's account of addiction as a rational choice, Lowenstein's examination of visceral factors, Goldstein's research, and Moss and Siegler's treatment clause. In chapter one, I discussed the viewpoint of Walter Glannon in relation to alcoholism and moral responsibility. Discussion established that moral responsibility is a matter of degree, and in the previous section, I

¹⁵² Harris, John (1995), Pg. 148

demonstrated that addicts are candidates for diminished responsibility. This section will focus on the factors that diminish responsibility in the case of alcoholics.

The American Medical Association classes alcoholism as a disease.¹⁵³ According to the Online Medical Dictionary, a disease is ‘an alteration in the State of Mind of the body or of some of its organs, interrupting or disturbing the performance of vital functions and causing or threatening pain and weakness.’¹⁵⁴ This definition makes no mention of the cause of the disease, but most believe a disease to be beyond the sufferer’s control. Alcoholism does conform to the above definition of a disease, but the alcoholic is also complicit in the development of the disease.

Avram Goldstein’s research showed the relationship between alcohol and genetics. Given this link, it seems rational to conclude that genes may play a role in the development of alcoholism, in some cases.¹⁵⁵ However, Gregory Pence points out that if a person is predisposed to genetically to a disease they usually almost suffer from it.¹⁵⁶ Whether or not Pence is correct in his assertion, it is true that alcoholics only develop alcoholism after engaging for a time in heavy drinking. The disease cannot develop without exposure to alcohol. This leaves room for environmental and familial causes.¹⁵⁷

¹⁵³ Ho, Dien (2008), Pg. 79

¹⁵⁴ <http://cancerweb.ncl.ac.uk/cgi-bin/omd?action=Search+OMD&query=disease>. *Date accessed 5th August, 2009.*

¹⁵⁵ Goldstein, Avram (1994), Pg. 93

¹⁵⁶ Pence, Gregory E. (2007) *The Elements of Bioethics* McGraw-Hill Companies Inc. : New York Pg. 40

¹⁵⁷ Pence, Gregory E. (2007), Pg. 40. See also Pg. 35 where Pence suggests that genes, influences in early childhood, social stress, and physical addiction all contribute to alcoholism.

While genes may play a role, exposure to alcohol is a key element in the development of addiction. After all, an alcoholic cannot become an alcoholic without drinking alcohol. I have already demonstrated that New Zealand has a prevalent drinking culture. Given the local drinking environment, and Lowenstein's findings in relation to the underestimation of visceral factors, it would seem that alcoholics in New Zealand are candidates for diminished responsibility. Moss and Siegler's theory requiring addicts to seek help for their addictions, once they are aware of them, seems to give an account of the degree to which this diminished responsibility can be applied.

The above findings seem to presuppose that during the time in which alcoholism develops an alcoholic is not responsible for their choices. Lowenstein's visceral factors theory is the root of this assumption. It is hard to disagree with Loewenstein's belief that individuals underestimate their susceptibility to addiction. However, when applying the visceral factors account to alcoholism there still seems to be something missing. Namely, the individual may underestimate the risk of becoming an alcoholic, but they still choose to partake in risky behaviour. An addict may underestimate their *personal* risk, but it does not follow that they must be unaware of any associated risks. The agent is likely to be aware that drinking large quantities of alcohol leads to health problems. They may not expect to become addicted but they cannot deny the possible negative health outcomes from engaging, even casually, in heavy drinking. This justifies accountability to some degree for the unhealthy behaviour.

In spite of Loewenstein's findings, there is still an inescapable component of voluntariness. It seems that, regardless of the underestimation of visceral factors, a potential alcoholic is still aware that alcohol can cause them harm, and yet they still choose to partake in drinking anyway. Herbert Fingarette rejects the belief that alcoholism is a disease. He asserts that alcoholics still have a degree of control over their behaviour.

5.2.2 *'Once upon a time...' the 'myth' of alcoholism*

*'Almost everything that the American public believes to be the scientific truth about alcoholism is false.'*¹⁵⁸ – Herbert Fingarette

Herbert Fingarette disagrees with the classification of alcoholism as a disease, and takes particular issue with Alcoholics Anonymous, the organisation dedicated to helping alcoholics recover from their addiction. Alcoholics Anonymous (AA) uphold the disease model of alcoholism suggesting that it is beyond the sufferer's control. They claim that the only cure for alcoholism is complete abstinence.¹⁵⁹ They advocate a 12-step programme that asks the alcoholic, firstly, to admit they have an uncontrollable problem. They also describe alcoholism as a sickness.¹⁶⁰ AA believes that blaming the problem on an uncontrollable disease relieves the alcoholics of feelings of shame and guilt, allowing them to begin recovery. They blame alcoholism on biological factors that trigger an uncontrollable need in the alcoholic for more alcohol. Complete abstinence is the only way to prevent this loss of control.

¹⁵⁸ Fingarette, Herbert (1988) *Heavy Drinking: The Myth of Alcoholism as a Disease* University of California Press : United States of America

¹⁵⁹ <http://www.alcoholics-anonymous.org.nz/>. Date accessed 5th August, 2009.

¹⁶⁰ <http://www.alcoholics-anonymous.org.nz/> (Is AA for me?). Date accessed 5th August, 2009.

Fingarete disputes that alcoholism is the disease which AA portrays it to be. This is not to say that AA's methods are unsuccessful. Their labelling of alcoholism as a disease, perhaps, allows the drinker to seek help, as they no longer feel responsible or ashamed of their drinking. However, it may also have the opposite affect with those who suffer from alcoholism using it as an excuse to continue to drink heavily because they 'can't help themselves'. The real question is the effect that labelling alcoholism as a disease has on responsibility.

One of Fingarete's chief arguments against alcoholism as a disease is that scientific evidence shows that alcoholics can moderate their drinking in a controlled environment. Experiments began in the 1960's to test whether or not alcoholics truly lost control over their impulse to drink.¹⁶¹ One of the classic experiments asked subjects to perform a trivially simple task in order to earn credit towards alcohol. These subjects could earn an ounce of bourbon in anywhere from five to fifteen minutes, depending on how fast they pressed a button. At any time a subject could earn enough alcohol to become intoxicated, but none did this. Researchers concluded that their observations were inconsistent with the loss of control associated with alcoholism, and that the amount of alcohol consumed was a function of the cost of alcohol and the degree of effort required to achieve it.¹⁶²

Given this evidence, it would appear that alcoholics are capable of moderating their drinking, given the right incentive. This means that alcoholism may involve addictive aspects, but the claim that it creates an irresistible impulse to drink is

¹⁶¹ Fingarete, Herbert (1988), Pg. 35

¹⁶² Fingarete, Herbert (1988), Pg. 35

false.¹⁶³ It seems fair to hold alcoholics morally responsible for their addiction if the desire to drink is controllable. This also lends weight to earlier discussion of Moss and Siegler's theory. If an alcoholic can control their behaviour then they are capable of, at least, seeking help if not recovering from the condition completely.

5.2.3 Who gets the liver?

It is time to revisit the theory of Moss and Siegler. They believe that alcoholics are responsible not for their initial decision to drink, but for seeking help for their condition. Therefore, they assert that those who seek help are less responsible than those who do not. In the final chapter, I discuss the 'Responsibility Continuum' and compare the case studies of four addicts (§ 6.4). Whether the addicts are more or less responsible, I do believe that those who seek help should be given diminished responsibility. This is akin to a brownie points system, which could inspire other addicts to quit.

The 'Responsibility Continuum' provides a grading system that ranks patient's claims to resources. The 'restoration argument' (discussed in Chapter Four) applies to the continuum, and it is only those who consume more than their fair share who are subject to ranking. Using three patients as an example illustrates this idea of ranking. Barry is an alcoholic who tried to quit several times, but was unsuccessful. He later developed liver disease. Linda is not an alcoholic, and developed liver disease through bad luck. Karen is an alcoholic who never tried to seek treatment, until she developed liver disease. Based on my discussion, Linda would be first in line to receive a new

¹⁶³ This is in contrast with other highly addictive substances such as cocaine. Goldstein describes that monkeys, when allowed free access to cocaine, will self-administer it to the exclusion of all other activities until they reach a state of sleepless exhaustion. Goldstein, Avram (1994), Pg. 155

liver, then Barry, and finally Karen (although, given the medical problems she is unlikely to receive a liver at all).

As can be seen from the above discussion, seeking help is not enough to absolve responsibility, but it does somewhat redeem the alcoholic. Of course, this is dependent on the availability and accessibility of treatment programs. There may be rare cases where treatment programs are not available or easily accessed, but the addict will need to prove these special circumstances.

Fingarette's research also supports the idea that alcoholics can seek help for their alcoholism. Alcoholics have been known to moderate their drinking when they feel familial or societal pressures. Therefore, it is not a stretch to believe that alcoholics are capable of seeking help for addiction. It would seem that if alcoholics can become aware of their dependency, then they are capable of treating it. They should be able to attend a treatment program if they are already able to obtain their drug of choice regularly. Therefore, whilst it may be unfair to hold an alcoholic accountable for becoming addicted, it is fair to hold them accountable for failing to seek the help they clearly need.

5.3 The difference between legal and illegal addiction

Drugs addicts fall into two groups, legal drug users, and illegal drug users. Alcoholics fall under the first group, as it is legal to purchase alcohol once over the age of 18 in New Zealand. While, there is a difference between alcoholics who seek help and those who do not, there is also a difference between illegal and legal drug

addicts. Illegal drug addictions can be harder to overcome, and more destructive to a person's health.

Addiction to illegal substances is subject to a greater degree of accountability due to the difficulty of maintaining the addiction. In order to become addicted to an illegal substance, one has to seek them out in a more direct way than alcoholics or nicotine addicts. This involves criminal activity, which has a negative impact on society. Given this association with crime, it takes a great psychological leap to cast off societal norms and partake in illegal behaviour. It is more difficult to become engaged in illegal drug addiction, and this gives ample time to consider the consequences. The opportunity to reflect on their behaviour, and the difficulty of obtaining the drug, makes the illegal drug user subject to a greater degree of culpability.

5.4 Conclusion

The issue of addiction strays into many different areas. Several authors have tried to account for addiction. Chrisoula Andreou shows that taking their substance of choice is actually the rational action for the addict, especially if the addict is suffering from withdrawal symptoms. However, this choice is only rational once the sufferer is addicted, and does not absolve them from responsibility for the initial development of their addiction.

George Loewenstein attempted to absolve addicts of responsibility through his account of visceral factors. Loewenstein believes that potential addicts underestimate

their susceptibility to future cravings. These individuals are more likely to become addicts. There remains a question over why these individuals, and not others, underestimate the future force of cravings.

Avram Goldstein, and research into genetic factors, demonstrated that there is a link between addiction and genetics. However, this link only accounts for a genetic predisposition, and does not mean that the subject will unavoidably become an addict. An addict cannot become so without indulging in an addictive substance. Most people are aware of the side effects associated with these substances; therefore, it is likely that the potential addict is also aware of them. Given the awareness of potential side effects, the addict must be aware that there is a degree of risk involved with consumption. Therefore, the addict is still responsible to some degree.

Moss and Siegler suggest that focussing on the cause of the addiction is less important than whether the addict seeks help. They believe that holding addicts responsible for seeking out treatment helps the addict to recover. This allows the addict to take responsibility for their addiction. Addicts who seek out treatment should be held less responsible than those who do not. This reward will encourage addicts to seek help, rather than give up on themselves.

Herbert Fingarette, who rejects the traditional disease concept of alcohol addiction, supports these conclusions. He believes that labelling alcoholism as a disease discourages alcoholics from taking responsibility for their addiction. Evidence suggests that Fingarette is correct, as it appears alcoholics can moderate their drinking when given the right incentives. This supports Moss and Siegler's theory; if addicts

can control their drinking in certain situations then they should be able to seek help. Therefore, alcoholics who seek help for their condition are less accountable than those who do not.

There is a significant difference between addiction to legal, and illegal substances. Illegal substances carry an element of risk, as they involve partaking in criminal behaviour. Maintaining an addiction to an illegal substance is more difficult, and therefore requires a greater degree of planning and forethought. Thus, addiction to an illegal substance carries a greater degree of culpability, than addiction to a legal substance.

Responsibility comes in varying degrees, so in the final chapter a system is proposed to account for this. The 'responsibility continuum' can compare different patients, and their levels of responsibility. Once ranked, it can be determined the amount that patient will be required to pay for their healthcare.

Chapter Six: Distributive justice and the 'Responsibility Continuum'

6.0 Introduction

Thus far, I have argued a case for distributing medical resources based on moral responsibility. Those who have played a role in the development of their illness have waived their right to health care, and thus, have a diminished entitlement to resources. In this chapter, I will look at some final issues regarding the theory.

The first point; is the distinction between brute luck and option luck, particularly in relation to genetics. The connection between genes and alcoholism was discussed in the previous chapter. However, I now plan to ascertain whether someone can be morally accountable for a genetic condition. I plan to argue that; while genes are usually a case of brute luck, they can be transformed to option luck if the patient in question chooses to remain ignorant regarding a treatable genetic condition.

As I demonstrated in Chapter Three, Bruce Waller disagrees with resource allocation based on moral responsibility as he believes the individual may not have control over their behaviour. John E. Roemer provides a theory of resource distribution that accounts for these factors. His 'Equality of Opportunity' theory allocates everyone a fair share of resources. Those who consume more than their fair share are doing so based on personal responsibility, and thus can be required through the 'restoration argument' to restore the resources.

The 'Responsibility Continuum' is a tool, which compares the moral responsibility of different patients. The amount of information known about the development of a patient's condition affects their placement on the continuum. Various examples will be used to demonstrate how the continuum can be used effectively by policy makers.

Throughout my discussion, various problems are identified that would only occur if the system was put into practice. In the final conclusion, I present my recommendations for the theory if it is to become social policy.

6.1 Brute Luck and Option Luck

Discussion in the previous chapter (§ 5.1.3) showed that genes can have an affect on moral responsibility, particularly as individuals can be predisposed to certain illnesses. Whilst genes do raise some interesting problems for the theory, it is not impossible to account for them.

John E. Roemer distinguishes between two types of luck; brute luck and option luck. Option luck is the outcome of a gamble specifically taken, and brute luck are results which the individual had no control over.¹⁶⁴ Oral cancer after 30 years of smoking would be the result of option luck, whereas oral cancer resulting from genetics is brute luck. Ronald Dworkin suggests that it is fair to hold individual's responsible for consequences of option luck, but not brute luck.¹⁶⁵ Therefore, any

¹⁶⁴ Roemer, John E. (1996) *Theories of Distributive Justice* Harvard University Press: United States of America, Pg. 248

¹⁶⁵ Roemer, John (1996), Pg. 248

conditions which develop as the result of genetics, and thus brute luck, the patient should not be held accountable for.

Genetic conditions are usually the result of brute luck, but they can transform to option luck. For example, a mother finds out she has a condition which involves the build up of iron in her blood stream (*haemochromatosis*).¹⁶⁶ This condition is treatable by regularly draining a small amount of blood. It is often a genetic condition, so her sons are also tested. When they were not aware of their genetic predisposition, the boys were candidates for brute luck. Once they had discovered that they may have the condition, and that it was treatable, choosing not to be tested transformed their option luck to brute luck.

In the previous example, the genetic condition is treatable. This makes it distinct from incurable conditions. If a patient is aware that they may have a genetic disease that is not treatable, such as Parkinson's disease, then being tested is not a matter of moral responsibility. The patient cannot prevent the disease by being tested, and so their luck remains brute. It is only those patients who suspect they may have a treatable genetic condition, who are responsible for being tested. These patients can potentially transform what is a matter of brute luck to option luck.

The above comments have interesting ramifications, in particular for women with a family history of breast cancer. Not having a double mastectomy could change their brute luck into option luck. To require women to amputate their breasts, if there is a chance of breast cancer, seems to be going a step too far. This is distinct from

¹⁶⁶ <http://www.netdoctor.co.uk/diseases/facts/haemochromatosis.htm>. Date accessed 3rd November, 2009.

genetic conditions which can be prevented by having a simple DNA, or blood test. Perhaps, it depends on the risk of breast cancer. Some women will have a 1 in 10 chance, but others may have a 9 in 10 chance. However, given that the mastectomy cannot prevent cancer from ever developing this seems like a drastic measure.

Whilst, brute luck can affect the outcome of a patient's health if they can reasonably take steps to try to prevent sickness, and do so, we would not hold them responsible. This means that only patients who have the necessary information and yet choose to act contrary to their own best health interests should be held completely responsible; those who transform their brute luck to option luck. Those who should be held responsible are the individuals that; know they have a high chance of developing the disease, choose not to get tested, and as a result develop a health state that requires more healthcare than would have been needed had they got tested. Those who engage in unhealthy behaviour without full knowledge of the consequences would be held less responsible (for they are still engaging in unhealthy behaviour). Brute luck isn't so much a problem for this theory but an aspect for the patient themselves to consider.

6.2 Roemer's account of distributive justice

*'My proposal endeavours to hold people accountable for just the right things, or just the things that the society in question thinks they should be held accountable for.'*¹⁶⁷ – John E. Roemer

In Chapter Three, Bruce Waller raised the concern that some individuals have natural advantages, which others do not. These advantages will have an affect on the individual's health behaviour. Some children are raised with parents who are good role models; they avoid smoking, drinking, and eat healthy foods, but some are raised with less than ideal examples. John Roemer suggests a way to account for these differences, known as 'Equality of Opportunity.' Accounting for those factors beyond one's control allows all individuals to be treated fairly, and does not favour one group over another.

In the previous section, I mentioned Roemer's distinction between brute luck and option luck; brute luck is entirely attributable to chance, and option luck is a result of a deliberate gamble. Brute luck can become option luck, if the patient deliberately chooses to remain ignorant of factors that lead to preventable ill health. Roemer suggests an 'Equality of Opportunity' policy, which attempts to account for the brute luck of aspects such as education, socio-economic status, parent's income, etc.

¹⁶⁷ Roemer, John E. (1998) *Equality of Opportunity* Harvard University Press: United States of America, Pg. 24

Roemer's aim is to come up with an account of resource distribution, which creates equality of opportunity.¹⁶⁸ The idea is to ensure that everyone is initially given equal opportunities when distributing resources provided by the state. After receiving equality of opportunity, it is up to the individual to exercise moral responsibility and make the most of it. This means that some children/individual's will have a larger fair share than others. Roemer originally trained as an economist, before moving into the area of philosophy so his theory involves economic utility calculations.¹⁶⁹ Given that my background is in philosophy only I have decided to omit these calculations.

The theory works by dividing everyone into different 'types,' based on levels of relevant 'circumstances.'¹⁷⁰ The circumstances are the factors considered to be beyond one's control. Examples of such circumstances are genetics, socio-economic status, geographical location, parent's income/education, the patient's education, and ethnicity. Roemer suggests that the policy makers or other relevant institution should be responsible for determining the relevant circumstances.¹⁷¹

When discussing the distribution of health care resources, Roemer uses an example of lung cancer. Roemer suggests that society must decide what the relevant circumstances are, that influence smoking behaviour. Once these circumstances are decided the population is divided into groups with other individuals who have the same values for the relevant circumstances. These are the 'types.' The smoking

¹⁶⁸ Roemer, John E. (1998), Pg. 5

¹⁶⁹ Indeed, Roemer himself states in the introduction to *Equality of Opportunity*, 'The preponderance of 'economic' sections is due not to my thinking that the philosophical aspects of the problem are easier or fewer but, rather, to my being a trained economist and an untrained philosopher. Consequently, my economic imagination is considerably more developed than my philosophical one, a personal misfortune reflected in the sectional distribution of my techniques.' Roemer, John E. (1998), Pg. 3-4

¹⁷⁰ Roemer deems these 'circumstances' to be environmental factors, which affect a person's choices, goals, and decisions etc., which are beyond the individual's control. Roemer, John E. (1998), Pg. 6-7

¹⁷¹ Roemer, John E. (1998), Pg. 8

behaviour will vary across each type, but the median number of years smoked can be calculated. Within a type, the behaviour that deviates from the median shows the differing degrees of responsibility that its members have exercised.¹⁷² Roemer uses an example to illustrate this idea further, outlined below.

Roemer describes two individuals from two different groups in which to illustrate the theory. One is a white, female, college professor, whose parents smoked until she was seven years old. For her group, she has smoked the median years which is eight. The other individual is a black, male, steel worker, whose parents were chain smokers. He has also smoked the median years for his group, twenty-five. Both of these individuals have smoked the median number of years for their type, so according to Roemer's system they have equal accountability. If the female college professor had smoked for twenty-five years – then she is more accountable for her smoking behaviour, as she has smoked eighteen years over the median.

Roemer's system fairly accounts for those factors which individual's cannot control. It ensures that those from disadvantaged backgrounds, not actively encouraged to engage to healthy behaviours, are subject to fair standards. Roemer's system ensures that not one group has an advantage, and everyone receives fair treatment. Using this system will also help to identify problem areas. These groups can be the focus of effective preventative medicine.

In this section, I have briefly outlined the theory of John E. Roemer and his account of equality of opportunity. Roemer believes that individual's should not be

¹⁷² Roemer, John E. (1993) 'A Pragmatic Theory of Responsibility for the Egalitarian Planner' *Philosophy and Public Affairs*, Vol. 22, Number 2, Spring Pg. 150 Cf. Roemer, John E *Theories of Distributive Justice and Equality of Opportunity*

held responsible for factors beyond their control, but only insofar as their behaviour correlates with the average behaviour of people with their relevant circumstances. If an individual's behaviour deviates from the median of their type then they should be held accountable (whether positively or negatively), ensuring that everyone is provided with a 'fair share' of healthcare resources. If they require additional healthcare resources, beyond their 'fair share,' then they will be required to restore the health resources they are unfairly consuming. In the next section, I will focus on one way in which to assign moral responsibility, the 'Responsibility Continuum.'

6.3 Degrees of responsibility: the 'Responsibility Continuum'

In chapter one, Roger Smith was introduced as a thought experiment. This example showed that relevant information affects the degree to which we are inclined to hold the agent responsible. In the case of Smith, additional information did not absolve him entirely of responsibility, but it did show that responsibility is not a case of a dichotomy of responsible or not responsible. Given this information, I have argued throughout this thesis that moral responsibility is a matter of degree. In this section, a tool is suggested which can be used to account for degrees of responsibility, the 'Responsibility Continuum.'

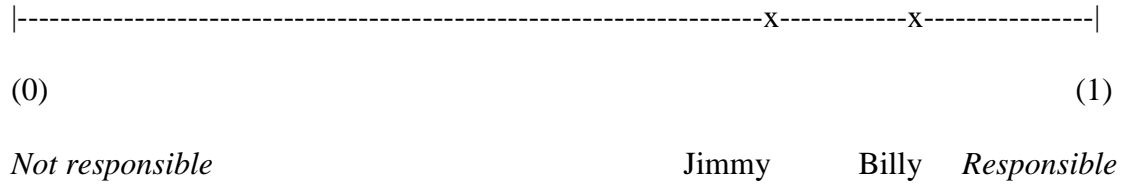
Based on previous discussion of responsibility, it appears that for any criteria used to assess responsibility there must be room for people to be more or less responsible than others. I have suggested several times throughout this thesis that responsibility falls on a *continuum* where some people can be held more responsible

his friends, he steals a packet of cigarettes from his mother and a lighter. He continues to steal cigarettes, for his friends and himself, until he is old enough to buy his own. Jimmy is twenty-five years old at the time of his first attempt to quit. This is unsuccessful, so he tries again at age thirty. By age sixty, Jimmy has tried to quit smoking five times. At age sixty-four, Jimmy is diagnosed with oral cancer, a result of smoking.

Now, some information about Billy. Billy has his first cigarette at a University party. His Dad smoked for a year when he was young, but was able to quit. Billy's mother never smoked. Billy begins by smoking socially, at parties and other social occasions, and then eventually starts buying his own cigarettes. By age twenty, Billy is buying several packets of cigarettes a week. Billy does not try to quit until he is thirty-five. By the age of sixty, Billy has tried to quit twice, and at age seventy-one he is diagnosed with lung cancer.

Learning additional information about the profiles of the two smokers shifts where they lie on the responsibility continuum. The information given pertaining to Jimmy seems to make him less responsible than Billy. Jimmy's parents were both smokers, so presented poor role models for that behaviour. Jimmy also tried to quit several more times than Billy. Billy's parents were not full-time smokers, and he began smoking when he was much older than Jimmy. Therefore, Jimmy is less responsible for his oral cancer than Jimmy is for his lung cancer.

Fig. 6.3 Jimmy and Billy’s revised position on the ‘Responsibility Continuum’



Currently, the placement on the ‘Responsibility Continuum’ is based on comparison between individuals. However, it may be possible to develop numeric values for unhealthy behaviours in order to compare responsibility. If such a system were to develop, it would require extensive research to ensure that the values are not simply arbitrary. If numeric values are developed for unhealthy behaviour, then perhaps credits could be given for healthy behaviour. Activities such as regular exercise, and healthy eating, may be assigned credit values. In this way, health resource allocation would not only account for unhealthy behaviour, but healthy behaviour also.

The ‘Responsibility Continuum’ system is compatible with John Roemer’s ‘Equality of Opportunity’. Roemer takes into account factors beyond an individuals control such as their economic status, education, and so forth. Roemer’s theory suggests that once all individuals have been placed in their subsets any behaviour that deviates from the median can be attributed to personal responsibility. Once they have deviated, individuals are liable for assessment using the moral responsibility continuum.

One other major advantage of the ‘Responsibility Continuum’ is that it overcomes the objection of consistency of judgments as raised by Dien Ho.¹⁷⁴ However, to make these judgments a considerable amount of information will be required regarding the individuals lifestyle. The individuals health state over time will need to be considered. It is likely that all citizens will be required to partake in annual health checks. Such regular check-ups already have precedents such as vaccinations, cervical smears, prostate examinations and mammograms. These are issues for consideration if the theory becomes health care policy.

Repeatedly, I have stressed the idea that responsibility attribution is not black and white. Various factors can influence responsibility, including; age, education, family background, and so on. Accounting for such factors is necessary when assessing moral culpability. Roemer’s system does account for those factors beyond a patient’s control, and the ‘Responsibility Continuum’ accounts for factors within their control. Combined, the two provide a formula, which distributes healthcare resources based on desert and merit.

6.4 Addiction and the ‘Responsibility Continuum’

In the previous chapter, the relationship between addiction and responsibility was analysed. Alvin Moss and Mark Siegler provided a theory, giving strong grounds for granting diminished responsibility; if an addict has tried to seek help for their addiction they are less responsible, than those who do not. Those who actively try to

¹⁷⁴ Ho, Dien (2008), Pg. 80

‘cure’ their addictions are still responsible to some degree, but they are less responsible than those who do not. In this section, these ideas are applied using the ‘Responsibility Continuum.’ In the previous chapter, I concluded that those addicted to illegal substances are subject to a greater degree of culpability compared to those addicted to legal substances. In this section, this idea is illustrated using four examples of addicts, with reference to the ‘Responsibility Continuum.’

Addict one: Addict one, Eddie, became addicted to alcohol at age eighteen. He began his addiction by drinking heavily at parties but this soon spiralled into a daily habit. By age twenty-seven, Eddie realises the toll that his drinking is having on his life. He visits Alcoholics Anonymous and is able to stay clean for twenty-six months before ‘falling off the wagon.’ He drinks heavily for three months before returning to Alcoholics Anonymous. This time he is able to stay sober for the rest of his life. At the age of sixty-five, Eddie is diagnosed with alcohol-related liver disease. He requires a transplant to survive.

Addict two: Addict two, Daniel, began drinking at the age of twelve. By the age of fifteen, Daniel is also a daily marijuana smoker. At age seventeen, a friend offers Daniel the chance to try methamphetamine. He immediately becomes addicted, and spends the next three years either taking the drug or conspiring to obtain it. He robs houses and shops at gunpoint, steals from his family and friends, anything he can to obtain money for his next fix. The police eventually arrest Daniel and, escaping detainment, he is sentenced to mandatory drug rehabilitation. He completes the rehabilitation programme but, his addiction is too strong, and he falls back into the

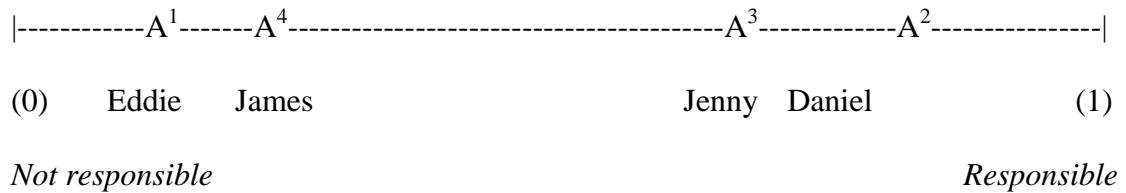
same cycle of criminal behaviour. During a robbery he receives a life threatening gun shot wound.

Addict three: Jenny is also an alcoholic. She began drinking at the age of twenty-seven, after suffering from post-natal depression. She continues to drink heavily for the next ten years. She separates from her husband, and he is given full custody of their children. Jenny is visited by friends, family, and members of a local community group. She admits that she is addicted but, refuses to go into rehabilitation. At age fifty-nine, she is hospitalised for liver failure. A liver transplant would save her life.

Addict four: James is a heroine addict. He became addicted at the age of twenty-two. By the age of twenty-four, he is homeless and jobless. His life is lived on the streets. He commits crimes to obtain drugs, and eventually becomes a drug dealer. He learns about an organisation that offers rehabilitation programs, free shelter and food whilst undergoing treatment. James enrolls in the program, but the lure of the drugs is too strong and he relapses. He tries again six months later, more determined, and successfully manages to complete rehabilitation and stay clean. Two years later he learns that he contracted Hepatitis C, and at age forty-nine his liver begins to fail. Without medical intervention he will not survive.

The case studies are divided into two types – illegal drugs users (Daniel and James) and legal drug users (Eddie and Jenny). Within the types, one of the users has sought help freely for their condition, and the other has not. The addicts are ranked on the ‘Responsibility Continuum’ (Fig. 6.4) below.

Fig. 6.4 *Four addicts on the ‘Responsibility Continuum’*



In Fig. 6.4, two of the addicts receive a lesser degree of responsibility as both Eddie and James sought help for their addictions. In a sense, they have received ‘brownie points’ for their attempts to seek help. A ‘carrot on a stick’ system like this will serve to encourage addicts to actively seek help, which is why I have chosen to rank them in this way regardless of the success of their efforts. Eddie is less responsible than James is, because he was not addicted to an illegal substance. Both of them should be able to compete for a liver transplant, with priority given to more innocent parties, and then Eddie and James.

Daniel and Jenny are held more responsible for their health states. Daniel has not undertaken a rehabilitation programme, or sought out help for his addiction. Again, Daniel is more responsible than Jenny because he is addicted to an illegal substance. As I mentioned in the previous chapter alcohol is a socially accepted substance in New Zealand. Until our drinking culture changes, those who become addicted to alcohol should be held less responsible than those addicted to illegal substances.

Applying Roemer's system to the above theory may change the rankings. For example, if none of the alcohol addicts had been addicted for more than the median years for their type, according to Roemer's system they are much less responsible. However, if Eddie had drunk more than the median number for his type, then he could be liable to a greater degree of responsibility, but his decision to seek treatment would lessen that responsibility. However, if Jenny had drunk less than the median years for her type then she would to a far lesser degree of responsibility than currently depicted on the continuum.

Roemer's system should not apply to illegal behaviours. This would undermine the law and render the public unsafe. For example, it could be suggested that there may be a median number of times that a particular man, in a particular type, can rape women before he is held responsible. This is clearly unacceptable and it would seem that to allow Roemer's system to apply to only some illegal behaviour is just a 'slippery slope.' Therefore, no median should apply to the use of illegal substances. However, if an illegal drug user freely seeks help then they should be held less accountable than those who do not.

Illegal drugs are, generally, more difficult to become addicted to, not because they are less addictive but because they are harder to obtain. This is why their practitioners are subject to a greater degree of culpability. For example, to obtain an illegal drug involves more effort than simply heading to the local pub for a few pints. It involves not only physical law breaking but also a rejection of societal norms, which can be very difficult for most individuals. There may be rare cases in which

obtaining illegal drugs is simpler, for example; celebrities. If this is the case then that individual may be a candidate for diminished responsibility. However, it is nearly always more difficult to sustain an addiction to an illicit substance and therefore those addicts should be held more responsible than their legal counter-parts.

Within this section, addiction was plotted on the 'Responsibility Continuum' using the example of four addicts. It was shown that differing degrees of responsibility can be expressed on the continuum, which allows for comparison between individuals. This ensures that responsibility judgments can be made fairly within the system. The 'Responsibility Continuum' is just one possible implementation of the system.

6.5 Conclusion

This chapter began with an examination of the difference between brute luck and option luck. I determined that genetic factors were a matter of brute luck, but can be transformed to option luck. This occurs when patients choose not to test themselves for preventable genetic diseases. It is fair to hold patients responsible for their option luck, but not brute luck.

I also presented Roemer's 'Equality of Opportunity' system in response to objections raised earlier by Bruce Waller. 'Equality of Opportunity' accounts for factors beyond an individual's control. The population is divided into subsets and their health behaviour is examined, based on the subset they were placed. Any

behaviour of an individual that deviates from the median of their subset results from personal choice, and thus personal responsibility.

I have also discussed at length the “Responsibility Continuum.’ This was another suggested way of assigning responsibility. Individuals are placed on the continuum, based on their health behaviour. Further information about how that behaviour developed effects the individuals is placement on the continuum. I have also demonstrated how the discussion in the previous chapter affects addicts placement on the ‘Responsibility Continuum.’ The ‘Responsibility Continuum’ is a useful tool, which aids in comparison between patients. The continuum also helps to clarify to what degree the patient is responsible, and therefore, what portion of their medical costs they may be fairly required to pay.

7.0 Overall Conclusion

This thesis has made a case for holding individuals morally responsible for their illnesses, through limiting their access to government-funded health care. The goal of such a policy is to ensure that government funding can continue to be a sustainable practice, into the future. It also ensures that innocent parties are not harmed by others unhealthy lifestyle choices.

Initially, I aimed to identify a theory of moral responsibility, which could be used to ascertain when an individual could be held accountable for their actions. Examination of several theories lead me to conclude that moral responsibility comes in varying degrees. I also argued that Walter Glannon's theory of causal responsibility could be useful when determining moral responsibility for health states

One of my greatest concerns was that one assertion could defeat my argument, regarding holding people accountable for their health states; that everyone has a right to health care. In Chapter Two, I examined this supposed right. My research showed that the right to health care might not exist, and there is ambiguity regarding what it actually entails. Given the controversy surrounding the right to health, I chose to assume that it does indeed exist, and attempted to prove that it could be overridden in certain situations. I demonstrated that Brennan's account of rights thresholds, and the idea that rights create associated moral duties, allows the infringement of the right to health, in certain circumstances.

The right to health did not present much of a challenge for the theory, so in Chapter Three I chose to examine other objections. These included objections from John Harris, Bruce Waller, and Dien Ho. Their objections were mostly on practical grounds, suggesting that it would be too difficult to implement such a system fairly. None of these objections presented strong challenges to the theory.

Another challenge was raised by Daniel Wikler; paternalism. Wikler argued that, in a society that values liberty, paternalistic policies are unjust, and are a form of governmental coercion. There is some doubt as to whether the policy I propose is, in fact, paternalistic. However, I chose to present a defence of paternalism to prove that it is not a strong objection. Rosemary Carter's theory of consent, and Simon Clarke's neutrality constraint, demonstrated that paternalism is justified in this situation.

The fourth chapter was devoted to discussion of the most convincing justification for holding patients morally accountable for their actions, the 'restoration argument.' Stephen Wilkinson, who attempted to defeat the 'restoration argument' with the 'reverse restoration argument,' attacked this argument. By acknowledging the moral difference between behaviours that harm an individual and have no social value, from those that do, Wilkinson's argument no longer holds.

Wilkinson's critique of the 'restoration argument' focussed particularly on smokers. During the course of my research, I noticed that many authors had focussed particularly on alcoholics and nicotine addicts, when discussing accountability for health states. This presents a problem; alcohol, and nicotine are addictive substances. I questioned whether it was fair to hold addicts as responsible as non-addicts.

Research into the topic was inconclusive, and time constraints prevent a deeper examination of the issue. It was concluded, however, that addicts share some responsibility in the development of their disease and are accountable for this role. I also concluded that those addicted to illegal substances are more accountable, than those addicted to legal ones.

In the final chapter, the link between option luck and genetics was noted. Normally, genes create brute luck, but if a patient knows they may have a treatable genetic condition, and chooses not to be tested, they can transform their brute luck to option luck. I also presented the theory of John Roemer in response to Bruce Waller's objections from Chapter Three. I believe that his distribution of resources, based on ensuring equality of opportunity, is the most just. Finally, I outlined the 'Responsibility Continuum,' a tool for assessing the moral responsibility of patients. The 'Responsibility Continuum' allows the comparison of degrees of moral responsibility. Placement on the continuum dictates the portion of health care costs that the patient must fund themselves.

I have chosen not to discuss some objections in the thesis. These are mostly practical objections regarding how the policy could be developed. Given that I have not trained in social policy, I am unable to solve these problems myself. However, I am confident that they do will present great difficulties, with careful formulation of the policy. Further research is required to resolve these issues. I have however discovered four final recommendations through the course of my research, which will be significant if the theory becomes social policy. These recommendations will ensure that holding patients accountable for their health states is fair to all, not just to some.

The first recommendation relates to the problem of information, which was first raised in Chapter One. When discussing the example of Roger Smith, I argued that the amount of information known the relevant circumstances effects moral responsibility judgments. For example, when we learned about Smith's background of child abuse he was seemingly less responsible. As such, in a system where moral merit dictates resource allocation, relevant information must be acquired over a period. To achieve this, the government may have to provide regular health check-ups to assess the patient's overall state of health. This will help to track unhealthy behaviours and habits over time, giving strong grounds for holding people morally responsible.

Not only does the government require information from the individual, but the individual also requires information from the government. Therefore, the second requirement is a system that regularly transmits up to date health information to the public, ensuring that none undertake risky behaviours without an awareness of the consequences. Guaranteeing that this information is accessible places a responsibility on the individual to consult it. Thus, the individual cannot claim that they were not aware of the risks if they are held responsible.

Both my requirements will require extensive funding, another problem for the theory. I have argued that medical funds are already straining, and cannot cope with the increased demand created by those who consume resources with preventable sickness. Given that the funding situation is dire, how can the country fund a policy that requires a complete overhaul of its current medical institution? My solution, and

my third recommendation; all funds gained from the policy must be diverted back into the system. Initially, a large investment from the government is required to cover the costs of set up. I have suggested that those morally accountable for their injuries, or illnesses, should have to fund a portion of their medical costs. This revenue will pay back the initial deposit, and continue to fund the system.

Reinvesting any money gained is essential to the functioning of the system. This ensures that only the public will profit. I believe it is important that the government does not benefit from holding people accountable, but rather the policy should be kept in line with the aims of the 'restoration argument' (Chapter Four).

The final significant recommendation is that a health insurance scheme is developed in conjunction with any policy involving moral responsibility. This insurance system should be government-owned to ensure that all New Zealanders are able to purchase at least a basic level of insurance. Government ownership is vital to ensure the reinvestment of all profits into the health care sector. The public will have the option of purchasing a basic insurance package, taking into account the risky behaviours that most would choose when behind, to use Rawls' terminology, a hypothetical 'veil of ignorance.' There must also be an option to purchase additional insurance for risky behaviours not covered by the basic package.

Overall, sub-textually this thesis stresses the importance of preventative medicine. The purpose of holding people accountable for their ill health is in a way another form of preventative medicine. The aim is to encourage healthy behaviour, and discourage unhealthy behaviour. Health education programmes will be vital in

ensuring that, from a young age, all individuals have the tools required to take charge of their health states. Without this knowledge, individuals are candidates for diminished responsibility.

If my final recommendations are followed then the entire country should benefit. I have already mentioned that my arguments tend to rely on utilitarian considerations, and it is for these reasons that I believe the theory should become social policy. The overall benefit; the entire population is healthier, achieved through an increased sense of personal responsibility for health, and an increase in funding. Initially, many people will be required to pay a portion of their medical treatment, but I believe that once the practice becomes established, this number will dwindle. The initial profits will cover the costs of the system, and any extra can fund preventative medical initiatives. Eventually, most will choose to forego unhealthy behaviour, in favour of living a healthy lifestyle. The healthcare system should eventually generate a surplus of funding, which could be spent in areas such as education, welfare, and criminal justice.

With medical resources becoming scarcer holding people morally responsible for their health states may not just be a possibility, it is our future. Initially, this may be an unpopular proposal, but I believe that most will accept some subsidised care, rather than none at all. In these difficult financial times, the country needs to survive and continuing to subsidise those who engage in risky behaviour is not feasible. This system provides a long-term solution with long-term benefits, and I believe, is the best option for the country.

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