Responding to Patients Who Take Risks with their Health

by

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ABSTRACT

This paper argues that it is impermissible for patients who have taken risks with their health to be denied treatments for any health problems arising from their risky behavior. It does argue, however, that it is permissible for patients who have taken risks for their health to be held responsible for the costs of treatment for any health problems arising from their risky behavior. Both of these arguments stem from the author's position on the right to health care, which is based on Norman Daniels' Equality of Fair Opportunity account. This paper further argues that while the right to health care is responsibility sensitive in principle, there are certain kinds of risks that are, for the reasons provided, acceptable risks, and that the responsibility sensitivity of the right ought not to be activated in cases where patients have taken these acceptable risks.

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Introduction

In 2002, Dr. Frederic Ross, a Winnipeg physician, made headlines when he announced to his patients that they could either quit smoking, or find another doctor.[1] In 2003, Dr. Claudio de la Rocha, a chest surgeon who performed all lung cancer operations in the Northern Ontario town of Timmins, announced that he would no longer perform operations on any patients who were unwilling or unable to quit smoking.[2] In 2001, Surgeons at the major hospitals in Melbourne, Australia announced that they would begin denying patients who smoke access to lung and heart transplants, lung reduction surgery, artery by-passes and coronary artery grafts.[3] Shortly after this policy was announced, a 56 year old male smoker died in a Melbourne hospital after having his surgery delayed.[4] In most of these cases, the physicians involved have cited the need to ration scarce medical resources as the primary reason for their policies.

While all of the above examples involve patients who smoke, similar policies have been suggested for alcoholic patients who suffer from alcohol-related end-stage liver disease,[5] obese patients who contract type-2 diabetes, and intravenous drug users who contract Hepatitis C and HIV through the use of dirty needles.[6] While some writers have made their arguments on this topic explicit, similar positions are sometime merely assumed in other works.[7] Some physicians have suggested that risk taking patients should not be treated at all, while other have suggested that priority should be given to those patients who have not taken risks with their health over those patients who have.

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[1] Canadian Press (Canada.com) http://193.78.190.200/10h/bad-doc.htm
[2] Toronto Star 4/11/03 http://www.quitsmokingsupport.com/buttout.htm
[3] Herald Sun. February 8, 2001. http://www.sweetliberty.org/issues/health/docsrefuse.htm
[4] Sky News. February 11, 2001. http://193.78.190.200/10/au2.htm
[5] Moss and Siegler 1991, 1295-1298
[6] Edlin B. R., et al. 2001, 211-214
[7] An example of this sort of assumption can be found in E. Kluge 1988, 93.

Others have suggested that in order to compensate for the increased burden on the medical system, risk taking patients should somehow personally bear the cost of their own treatment.

There can be no doubt that health care delivery in Canada, and many other countries with socialized medical systems, is in serious need of reform. In 2003, health care already encompassed 10% of our gross domestic product,[8] and with the advent of ever more expensive medical technologies, that number has grown and will continue to grow into the future. Cost rationing will be an essential component of keeping health care costs at a manageable level. It is essential however, that in our efforts to control the costs of our health care system we do not unintentionally create injustices within that system, or within society in general.

The purpose of this thesis is to carefully examine the issue of how the health care system should treat patients who have taken risks with their health and as a result have contributed to the development of their own health problems. The question of how to treat risk takers is really a question about the right to health care. Is the right to health care something we can forfeit through our actions, or is it completely inalienable? In this paper, I will offer an account of the right to health care, and I will argue that it cannot be forfeited by our actions. I acknowledge however, that there is an ever growing need to recover the costs of treating risk takers, many of whom place significant burdens on national health care systems. To accommodate this need, I will argue for an account of the appropriate response to those who take significant risks with their health, and offer a model for cost recovery that would help control costs without violating citizens' rights to

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[8] Canadian Institute for Health Information.
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_17dec2003_e

health care.

The discussion that follows is conducted at the level of social policy making, and as such it does not deal with questions of micro allocation or duties of individual physicians to their patients. I will be considering two primary questions. First, would it be acceptable to withhold treatment from risk taking patients altogether? Second, can we place the financial burden of treatment onto those who played a causal role in the development of their own health problems? In this paper I will not be addressing the issue of whether non-risk takers should receive priority in situations of extreme scarcity.[9] In this paper, I will be addressing only the issue of how to respond to risk takers under the conditions of what we will call "normal" scarcity.[10] The issue of prioritization under extreme scarcity is both interesting and important, but to address it would take an entire paper of its own. Nonetheless, I believe that some of the arguments I will offer here will be relevant to any future discussion of prioritizing non risk takers under conditions of extreme scarcity.

Further, I should note that when discussing whether physicians should withhold treatment from risk takers, I am referring only to those treatments for health conditions that can be properly understood as appropriately connected to the risks that were taken. If a particular patient chooses to increase her risk of liver damage by chronically drinking to excess, but then injures her knee while playing basketball (while sober), there is no reasonable case for withholding treatment, since there is no connection between the health risks and the health problem. This applies most significantly to general

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[9] These are usually cases such as those discussed by Moss and Siegler, which involve a limited number of organs for transplantation.

[10] "Normal" here just refers to the levels of scarcity usually faced in a system. It will include nearly all usual operations and treatments, excluding those that involve very limited, virtually non-renewable resources, such as liver transplants.

practitioners such as Dr. Frederic Ross, who deal with a wide variety of health problems. While a case might be made that a GP has grounds to refuse treatment to a smoker for a smoking related illness, that same GP could not reasonably refuse the same patient treatment for chronic back pain.

In chapter one of the paper, I will discuss Gerald Dworkin's attempt to address the issue of how to respond to patients who take risks with their health. Dworkin focuses primarily on the notion of responsibility, rather than on the right to health care. I will argue that while Dworkin makes a valuable contribution to the debate at hand, his own account is insufficient to resolve the issue.

In chapter two, I will consider two different accounts of the right to health care, those of Allen Buchanan and Norman Daniels. I will argue that Buchanan' s pluralistic account of the right to health care is problematic, and as such, is not the most compelling account available. I will go on to argue in support of Daniels' theory, which is based upon a Rawlsian principle of equality of fair opportunity. While I will express some concern with a few elements of his approach, I ultimately will endorse Daniels' account of the right to health care.

In chapter three, I will discuss whether we can hold risk takers liable for the costs of their health care. In the first part of the chapter, I will argue that equality of opportunity, the principle that underlies the right to health care, is in principle sensitive to personal responsibility. In the second part of the chapter, I will offer a discussion of acceptable risk, which will elaborate on the conditions that must be met for the responsibility sensitivity of the right to be engaged.

Chapter 1

Dworkin's Philosophical Apparatus

Before offering my own argument against refusing treatment to risk takers, it would be useful to examine an alternative approach to the question at hand, and explain why this approach alone is not sufficient to resolve the problem. To this end, I will begin my discussion by examining Gerald Dworkin's answer to the question of whether treatment should be refused to those patients whose voluntary assumptions of risky lifestyles contributed to the development of their illnesses. In "Taking Risks, Assessing Responsibility," Dworkin's approach is to focus his discussion on various ideas of responsibility, and relate this philosophical material to the issue of formulating health policy.[11] As the term "responsibility" tends to be used in several distinct ways, Dworkin begins his discussion by clarifying the distinctions between the conceptual (questions of causation) and normative (questions of what consequences of actions people ought to be held accountable for) uses of the term. Following Hart,[12] Dworkin divides the differing meanings of "responsibility" into three broad categories: *role-responsibility*, *causal-responsibility*, and *liability responsibility*.

Role-responsibilities are those duties and obligations that accompany distinctive places in social life. As an M.A. student, I have the responsibility of writing this thesis. As health-care professionals, doctors have the responsibility for caring for their patients. Obviously, not all role-responsibilities are voluntarily assumed, as there may be specific duties that follow from one's role to which one did not explicitly agree. A doctor, for example, cannot disregard confidentiality simply because he or she never explicitly

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[11] G. Dworkin 1981, 26-31
[12] H.L.A. Hart 1968, 211

agreed to such a duty, since such a duty comes with the role. While in this case the duty is not voluntary, the assumption of the role is. There are other cases, however, such as the role of a child and the corresponding responsibilities towards aged parents, in which neither the specific duties, nor the assumption of the role will be voluntary.

Causal-responsibility deals with empirical questions about how the world operates. When we ask who or what was responsible for a plane crash, we are asking what caused the crash, not whose role-responsibility it was to cause or prevent the plane crash. As Dworkin points out, attributing causation is rarely a straightforward or easy process, since "There will often be many causal contributors to an event, in the sense of events that were necessary for the given event to occur."[13] When attributing causal-responsibility, we are usually trying to identify one major or important cause from among the list of necessary, sufficient, and contributing conditions that obtained in a given situation. In identifying something as *the* cause of a particular event, we are making judgments that select some factors as significant, illuminating, or morally noteworthy. Frequently, one of the interests that will guide our judgments is the need to assign liability for a particular outcome.

Liability-responsibility deals with legal and moral judgments regarding blameworthy aspects of a person's behavior. Liability-responsibility may involve legal punishment, or it may be restricted to an attribution of negligence. According to Dworkin, there are two distinct elements that are involved in the ascription of liability-responsibility: culpability and liability. One is culpable when a harm done is in some way the product of some faulty aspect of oneself or one's conduct. One is liable when certain consequences do or ought to flow from oneself or one's conduct. In the case of

[13] G. Dworkin 1981, 27

liability in the law, the assignment of liability need not involve a judgment of culpability. Judgments of culpability look to the past; they establish fault and assign blame for actions taken. Judgments of liability on the other hand, look to the future; they make demands on a person to do something or on others to act towards him/her in a certain way.[14]

We may be responsible then, for our actions and our behavior, as well as the consequences (what follows causally) of initiating or continuing that behavior. Here Dworkin draws another distinction, this time between three classes of consequences for which one may be considered responsible. First, Dworkin identifies the *possible* consequences of one's acts. This is the category of risk-creation, and it includes the events that are likely to come about as a result of one's actions. On this view, Dworkin points out that though the risk created may not produce harm, this will not necessarily absolve one from responsibility for the creation of the risk. As he explains, "The drunken driver may not hit anyone but he is responsible for endangering the lives of others just the same."[sic][15] [16]

The next set of consequences that one may be held accountable for are the *actual* consequences of one's behavior. This class includes harms that result from some action for which one was causally responsible. On this view, one may be held culpable or liable for harms that result from long and attenuated chains of causation, so long as there is an

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[14] G. Dworkin 1981, 28
[15] G. Dworkin 1981, 28
[16] Here Dworkin adds that while the drunk driver who does kill a pedestrian is liable for manslaughter, another drunk driver who is fortunate enough not kill anyone is guilty of a much lesser crime in the eyes of the law, though according to him there is no good moral or legal reason for such a differentiation in the degree of punishment. Dworkin is here touching upon the problem identified as 'moral luck' by Thomas Nagel (1979). This issue will be addressed in more detail in chapter 3, when discussing risk and responsibility.

appropriate connection between one's actions and the resulting harms.[17]

This brings us to Dworkin's final class of consequences; those that are *foreseen or reasonably foreseeable.* On this view, one is responsible for those harms that result from one's behavior if one was aware of the possibility that they might occur, or one was negligent in not thinking about their possibility. This class excludes harms created by an excessively long causal chain (long enough that the resulting harms were unforeseeable), or those created by intervening factors that were purely accidental (purely chance and therefore unforeseeable).[18]

Dworkin's Argument on Liability

Having constructed his philosophical apparatus, Dworkin goes on to apply it to the issue of individual responsibility for health risks. He begins by considering the significance of the claim that individuals are responsible for their health. If interpreted as a statement of role-responsibility, he points out that this claim would differ in important ways from most typical cases. Responsibility for one's own health is not a role within an institution defined by rules, statuses, expectations, and sanctions, nor is it voluntarily assumed. Further, unlike many other role-responsibilities, there is no appeal to the interests, rights, or welfare of other people. Finally, there is an ambiguity regarding boundaries of such a responsibility. How much time and energy must be devoted to one's health, and how are conflicts with other role-responsibilities to be resolved?[19]

The claim of personal responsibility for health can also be interpreted in terms of causal-responsibility and liability-responsibility. To illustrate this, Dworkin cites Robert

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[17] Here Dworkin is drawing upon Keeton's argument for appropriate connection in causal chains. G. Dworkin 1981, 28
[18] G. Dworkin 1981, 28-29
[19] G. Dworkin 1981, 29

Veatch's point that "If individuals are responsible to some degree for their health...why should they not also be responsible for the costs involved?"[20] Here Veatch's use of "responsible" differs from the premise to the conclusion, and in neither case is he invoking role-responsibility. The premise makes a claim about causal-responsibility; it implies that life styles of individuals causally affect their health, at least to a degree. This is an empirical claim about causal determinants, which, as Dworkin pointed out earlier, involves a judgment about which factors contributing to an event are particularly relevant or noteworthy. As our judgments will be influenced to some degree by our interests, he suggests that we might expect that ideological disputes will arise when assigning causal responsibility. Is it the smoker, the grower of the tobacco, or the manufacturer of the cigarettes who causes a particular case of lung cancer? Says Dworkin, "It is easy enough to identify the choice of a man to smoke as a necessary condition for the development of his particular lung cancer but there were lots of other necessary conditions that we do not cite as causes... Selecting his smoking behavior reflects a particular view about causal-responsibility or about liability-responsibility."[sic][21]

The conclusion of Veatch's comment makes a claim about the liability-responsibility of individuals for their health problems, and it is this interpretation of the claim of personal responsibility for health that seems most to illuminate the current question of treating risk takers. To make a claim about individual culpability for health problems however, is really to claim two things: that an individual was in some way at fault in his/her behavior and that the faulty behavior produced the relevant health

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[20] G. Dworkin 1981, 29
[21] G. Dworkin 1981, 29-30

problems.[22] We have already seen that it will not be entirely straightforward to establish the second claim, since while an individual's behavior may be a necessary condition in the development of their health problems, it will rarely be the only relevant necessary condition, and as a result, it may be misleading or inaccurate to cite the individual's behavior as being causally-responsible for the health problem.

According to Dworkin, while attributing causal-responsibility may be somewhat problematic, the fault condition in the attribution of culpability is the more controversial, since as with any attribution of fault, there are at least two ways of arguing against it: excuse and justification. By offering excusing conditions, one can attempt to show that a particular faulty behavior does not originate in the defective character of an individual, but rather in circumstances external to that character and therefore the behavior is not (fully) voluntary. For example, one might suggest that people eat unhealthy things because they do not have the time and information to make proper choices.[23] One may also seek to avoid culpability by offering justification for an alleged faulty behavior. For example, one may argue that while being a fire fighter poses significant health risks, society needs people to take such risks, and therefore a person in such an occupation is not at fault for health problems that result from their job. Dworkin points out that both of these strategies assume an initial burden of proof to show that what appears to be defective behavior is really not, but that another strategy that can be used is to reject the burden of proof altogether, and argue that one's health is one's own concern. This view

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[22] Dworkin adds a third claim, which is that the faultiness of the behavior created the damage to health. This is really only added as an afterthought and is included to rule out bizarre cases such as Jones who smokes too much, and because of his short-windedness is not able to outrun the rabid dog who bites him and makes him sick. G. Dworkin 1981, 30

[23] There are any number of examples for this sort of excusing condition: people drink because of genetic predispositions or because they are unhappy and cannot find other ways of relieving stress; people smoke because they are manipulated into such behavior by advertising or peer pressure; etc. G. Dworkin 1981, 30.

holds that there is no obligation to preserve one's health, so therefore the whole notion of fault is inappropriate in this context.

In order to examine the issue of liability-responsibility for health problems free from the objections of excuse or justification, Dworkin suggests that we consider a theoretical model of a particular class of behavior. For this class, Dworkin wishes us to imagine that the behavior is fully voluntary, and that the causal link between the behavior and the actual damage is straightforward and easy to ascertain. Further, he asks us to imagine that avoiding the behavior is not difficult, that the satisfaction from engaging in this behavior is not very significant, and that there is no obvious social justification for the behavior. Taking this set of assumptions, Dworkin moves on to consider what normative conclusions might follow, and which of these conclusions might be acceptable.

The first inference that Dworkin considers is that those who provide medical care ought to refuse to do so for those individuals who have engaged in the class of behaviors described above, and have developed the appropriately connected health problems, *even if* the patients in question are able and willing to pay for such services. This policy has a few features in its favor, namely that it may have a strong deterrent effect and it would probably free up some medical resources that could be used in other areas. As Dworkin points out however, while it may be reasonable to impose some sort of penalty on those who have voluntarily damaged their health, leaving these same people in pain and suffering cannot be appropriate.[24]

According to Dworkin, the strongest plausible inference that can be made in this case is that the class of behavior described above would be morally relevant when physicians have to make choices between patients due to harsh scarcity of resources.

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[24] G. Dworkin 1981, 30

Thus, if the last bed in the ICU could be used either for someone who was injured in a car accident due to not fastening her seatbelt, or someone who was injured by a drunk driver while crossing the street, it is morally relevant to take into account that one patient voluntarily contributed to her health problem while the other did not.[25]

According to Dworkin, this suggested policy is clearly not motivated by consequentialist considerations, since any deterrent effect it will have will be very small in light of the rarity of such occurrences.[26] In his view, this policy must be motivated by the assumption that the "bad" patient has forfeited some consideration to equal treatment. He suggests that the obvious analogy must be to the case of the criminal who has forfeited his right not to be injured. Of course, Dworkin is quick to point out that the disanalogies between the two situations are significant. In the case of the criminal there is deliberate intent to create an unequal situation between two parties with full knowledge that this has been forbidden by society. "Because the individual is, in Kantian terms, acting on a maxim that involves distinguishing himself morally from others (by taking liberties that he denies to others) we are entitled to deprive him of certain rights."[27] The "bad" patient however, may be perfectly willing to generalize his conduct, and therefore he would not be asking for an exception to be made for himself. As such, Dworkin claims that no argument has been given for why the "bad" patient has forfeited his right to equal consideration in treatment.

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[25] This is very similar to the position that Moss and Seigler develop when they argue that when applying for liver transplantation, patients who suffer from liver failure through no fault of their own should receive priority over alcoholics who develop end-stage liver failure due to their chronic drinking problem. Moss and Siegler 1991, 1295-1298

[26] While he is probably correct in his assertion that there will be little deterrent effect from such a policy, Dworkin is clearly mistaken in his claim that this argument is not motivated by consequentialist concerns. A quick glance at Moss and Siegler's arguments in favor of preferential treatment for non-risk takers will shows that their concerns are primarily consequentialist. Moss and Siegler 1991, 1295-1298

[27] G. Dworkin 1981, 31

Dworkin also points out that a further problem arises when comparisons are drawn between the "good" patient and the "bad" one, since the "good" patient may in fact be taking comparable or greater risks than the "bad" one, but be fortunate enough to have his current health problems arise from involuntary origins. In such a case, which patient is considered "bad" may be a matter of luck, and Dworkin clearly believes it is problematic for the alleviation of human suffering to depend on such contingencies.

The other relevant policy that Dworkin considers is that people who engage in the class of risky behavior discussed earlier ought to be liable for the cost of their care. This sort of policy could take several different forms, and while those Dworkin discusses are tailored to the American health care system, they are all analogous to policies that could be implemented in a more fully socialized system such as Canada's. First, Dworkin suggests that those who are currently subsidized by the state through Medicare or Medicaid for their health care might be denied such subsidy. The analogous policy in a socialized system in which everyone's care is subsidized would be that those who take risks with their health would not have their treatment paid for by the state, and that therefore the risk taking patients would be directly responsible for the costs of their treatments. Alternatively, Dworkin suggests that those who take part in a national health insurance program might have to pay higher premiums. In a socialized system, an analogous policy might require risk takers to pay extra premiums to the state to cover the increased risk of their burdening the system with their extra health problems.[28] Finally, Dworkin also suggests that those who engage in risky behavior might have to pay a tax that would be used to finance health care and research related to the appropriate health damage.

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[28] In British Columbia, for example, annual MSP premiums could be increased for risk takers.

Rather than examine any of these particular policies in detail, Dworkin instead focuses on the more basic question of whether the fact that a person voluntarily takes a risk with their health (causal-responsibility) is sufficient justification for the normative claim that the person therefore ought to be liable for the financial burden of his or her treatment (liability-responsibility). According to Dworkin, there are several arguments that contribute to the plausibility of this jump from causal-responsibility to liability responsibility. He first outlines a utilitarian position, which argues that since the health hazard is within the control of the agent, it is avoidable. Therefore, holding the agent responsible for the costs of such risks acts as an incentive to hold the risks down. Second, an argument from efficiency can be offered that holds that while there may be other ways of reducing risk, having the agent exercise choice may be the cheapest. Third, Dworkin suggests that the demands of fairness would contribute to such a jump, since people ought to bear the costs of their activities. Finally, Dworkin suggests that "we may view the moral importance of the fact that risks are chosen as the appropriate compromise between our wish to be able to make claims upon others for help... and the need to draw limits upon the claims made by others."[29]

Taking the above four arguments together, Dworkin admits that a reasonable case can be made that individuals who take risks with their health ought to be liable for the costs of their treatments, so long as the very strong set of assumptions he has described (that the risks are voluntary, that there is no social justification, etc.) remain in place. When these assumptions are weakened however, Dworkin believes that the case for holding risk takers liable for the costs of their care will quickly begin to deteriorate. Some of the problems Dworkin anticipates include the mixed character of the

[29] G. Dworkin 1981, 31

voluntariness of many behaviors, and the difficulty in determining the relative causal role of voluntary vs. nonvoluntary factors in the genesis of illness. Ultimately, Dworkin concludes that while basic considerations of justice will show that it is not unfair to require *some* risk taking patients to bear the costs of their treatment, the question of whether we ought to do so will depend upon the very complex balancing of how much good we can accomplish through such a policy versus the harms and injustices that would arise from such a policy.[30]

Criticisms

Before offering my criticisms of Gerald Dworkin's position, I must point out that I agree with a great deal of his argument. He offers some interesting and useful insights, but unfortunately, there are two problems with his approach to the issue of risk taking patients. First, he does not conceive of risks as gambles, nor does he discuss the distinction between option luck and brute luck.[31] This proves to be a problem, because he is unable to accurately portray the differences between what he calls the "good" patient and the "bad" patient. The second problem with Dworkin's argument is that he does not approach the problem as a question about the right to health care. As a result, Dworkin's discussion fails to deal with basic issues such as whether citizen's right to health care should be responsibility sensitive at all. I will now consider both of these issues in detail, and explain why any acceptable account of the problem at hand must address both of these issues if it is to be successful.

When we take risks, whether with our resources or with our health, we are engaging in gambles. When facing a particular risk, we define our possible options for

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[30] G. Dworkin 1981, 31

[31] This distinction will be explained later in the chapter.

action, and identify the potential consequences of each option and their likelihood of occurring should a particular option be adopted. We then evaluate our options for action based on our assessments of the likely consequences of our choices, and the varying desirability of these consequences.[32] The desirability of a particular consequence will be based on our values, and as such it will be inherently subjective and context specific. One of the central values that will play into a particular decision will be our individual degree of risk tolerance. While some individuals are quite willing to take significant risks in order to pursue their goals, others are far more conservative and prefer to "play it safe."

When deciding how to manage my resources, I am faced with many possible actions, all of which have many potential consequences. I might invest my resources in the stock market, knowing that the market may improve, but also knowing that there is a risk that stocks will fall in value. Similarly, I may invest in bonds or in real estate, and in each case the consequences might turn out to be good or bad. While I may be able to calculate that the bond market is less volatile than the stock market, I cannot predict any outcomes with certainty. In making my decision, I must balance the desirability and probability of the potential positive consequences with the undesirability and probability of the potential negative ones. If I judge it likely that I would lose all my money on the stock market, and I find this consequence undesirable and I am highly risk averse, I will likely choose to invest in bonds or real estate in the hopes of playing it safe and holding on to my money. If however, the potential pay off of investing in stocks is very high, and I am very tolerant of risk and greatly desire more money, I may choose to invest in stocks. In either case, I am gambling based on the desirability of the potential

[32] Fischhoff, et al. 1981 2-3

consequences and my assessment of the likelihood of their coming to pass.

When we take risks with our health, we are gambling in the same way as when we decide how to manage our resources. Let us consider the example of Dana, a smoker who is trying to decide whether or not to quit smoking. For simplicity's sake, let us imagine that Dana has two only two options, either to quit smoking altogether or to continue smoking at her current intake. After identifying her options, Dana will consider what consequences she can expect from either choice, the desirability of the various consequences, and the likelihood that these consequences will come to pass. If she quits smoking, there is a much lower chance that she will develop heart disease or lung cancer than if she continues to smoke. Further, there is a chance that her cardiovascular system will improve and that she will have more energy. She may also save money, since she will no longer need to spend money on cigarettes. There is also a very high chance, however, that Dana will cease to gain the pleasure she did from smoking, and that she will suffer significant discomfort from withdrawal symptoms. There is also a chance that she will become very moody in the short term, and that her grouchiness will negatively affect her relationship with her partner.

If she does not quit smoking, Dana faces a converse set of consequences. She will remain at high risk for heart disease and various cancers, and may die prematurely as a result of one of these diseases. She will also continue to spend considerable resources on cigarettes, and will continue to impede her cardiovascular system. She will, however, be able to continue to enjoy smoking and avoid the significant discomfort of nicotine withdrawal (both for herself and her partner). Whichever choice she makes, Dana's decision will be based on how likely she believes the various potential consequences to

be, and how desirable those consequences are to her. If she believes that she is very likely to contract lung cancer if she continues to smoke, and this consequence is extremely undesirable to her, then she is likely to choose to quit, assuming there are not equally likely and undesirable consequences to quitting. If however, she believes that it is not very likely that her health will suffer from continuing to smoke, and the discomfort of withdrawal is supremely undesirable for her, then she may instead choose to continue smoking. Either way she runs the risk that she will be wrong about which consequences come to pass.

Whether she chooses to quit or not, Dana is making a deliberate gamble. Both choices involve risk, and she is evaluating the various odds, and her own disposition towards the possible consequences, with the hope that the results of her gamble will be to her benefit. Of course, Dana's decision whether or not to quit smoking will probably not be made in as calculating a way as my own decisions regarding how to invest my savings, but the underlying logic of the gambling process is the same in both cases: we both knowingly take the risks from which we expect to benefit most.

When making decisions about risks, we perform a balancing act, and choose the action that we believe will best suit our particular goals. In making any risky decision, we make a gamble and hope that the consequences we view as desirable will obtain, while those we view as undesirable will not. As with any gamble however, there will always be a chance that we will "lose;" that the actual consequences will not be desirable. While we can attempt to calculate the likelihood of particular consequences obtaining, whether a particular gamble will in fact work out in our favor will be a matter of luck. This kind of luck however, differs in an important way from the luck we have when we

are the subjects of an unpredictable, unintended catastrophe, such as being struck by a meteorite. To explain this difference, I will borrow the distinction Ronald Dworkin makes between *option luck* and *brute luck.*

Ronald Dworkin defines option luck as "a matter of how deliberate and calculated gambles turn out – whether someone gains or loses through accepting an isolated risk he or she should have anticipated and might have declined."[33] Brute luck on the other hand, "is a matter of how risks fall out that are not in that sense deliberate gambles."[34] If I play roulette and win, or if I invest in real estate and the market appreciates, then my option luck is good. If I am swept away by a spontaneous tornado that I could not have foreseen or avoided, then I am a victim of bad brute luck. Dworkin points out that the difference between these two forms of luck is best represented as a matter of degree, and that we may sometimes be uncertain of how to best describe a particular piece of luck.[35] In most cases however, the distinction between option luck and brute luck will be a clear one and relatively easy to identify.

The conception of risks as intentional gambles and the subsequent identification of the results of intentional gambles as instances of option luck rather than brute luck together pose significant problems for Gerald Dworkin's argument. As discussed earlier, Dworkin believes that ascriptions of fault (liability responsibility) for a particular behavior can be defeated by claiming justification for that behavior. For example, mountain-climbers may claim that they are not at fault for running health risks, since they have a right to define themselves as persons who take risks as a part of a certain ideal of

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[33] R. Dworkin 1981, 73
[34] R. Dworkin 1981, 73
[35] R. Dworkin 1981, 74

human excellence.[36] If we understand their risk takings as deliberate gambles however, it is difficult to see how their "justification" would absolve them of responsibility for the risk. Attaining a certain ideal of human excellence is a benefit the climbers expect to obtain from their gamble. It is one potential consequence, presumably one they desire, of one action they may take. Suffering serious injury or death are other potential consequences of the same action. The climbers choose to climb mountains in the hope that certain consequences, those that they desire, will obtain.

That we consider the climbers to have the right to make this particular gamble does not entail that we believe they are not responsible for the consequences of the risks they accrue; quite the opposite. If I were to gamble all my money away playing roulette, and then claim that I was justified in my risk taking because I was seeking to fulfill my right to pursue material wealth, I may well be correct. If I were to further claim however, that I should therefore be given my money back, I would be quite mistaken. In making an intentional gamble, I knew that there was a chance I would win, and a chance I would lose. That was the risk I chose. The fact that I desired to win is in no way sufficient to excuse me from the negative consequences of losing. There is simply no appropriate connection between the two.

The fact that I have a right to pursue material wealth allows me to take certain gambles if I wish to. I may even claim that I am "justified" in taking certain risks if I have sufficient reason to believe that the consequences that I desire are reasonably likely to occur, or that I desire the benefit with sufficient intensity to overcome my risk aversion. But here justification does not imply an absolution of responsibility, but instead only that I may have had good reason for my decision. We may agree with the

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[36] G. Dworkin 1981, 30

climbers that they have the right to risk their health by climbing mountains, and that by doing so they achieve a certain ideal of excellence. We may even agree that they have good reason to take the risk, and so in that sense are justified in their actions. We are by no means however, obliged to accept their claim that they are not liable for their risky behavior, just because they desired the potential positive consequences of their risk taking.

Eliminating the justification claim poses a problem for Dworkin, because he assumes that it will prove to be a way to weaken the argument for holding risk takers liable for the costs of their care, since some risk takers could claim that they were justified in taking risks, and should therefore not be held liable for their behavior. Without the justification argument, Dworkin is left with one less way to erode the personal culpability of risk takers.

Dworkin next runs into problems when attempting to distinguish between what he calls the "good" patient and the "bad" patient. As discussed earlier, Dworkin rejects the notion that non-risk taking patients should be given priority over risk takers when physicians are forced to make choices between patients due to harsh scarcity of resources. He suggests that for the argument to work, the "bad" patient must have forfeited some right to equal treatment, and that the obvious analogy is to the criminal. He believes this fails however, since the "bad" patient might be perfectly willing to generalize his conduct (in Kantian terms), and so is not trying to distinguish himself morally from others.[37] By doing away with the criminal analogy, Dworkin assumes that he has done away with any legitimate moral distinction between the "good" patient and the "bad" one.

Dworkin's mistake here is that he has not distinguished between option luck and

[37] G. Dworkin 1981, 31

brute luck, and as a result he draws the very poor analogy to the case of a criminal. A risk taking patient is distinct from the non risk taking patient, because the risk taker's health problems in this case are the result of bad option luck, while the non risk taker's health problems are the result of bad brute luck. The risk taking patient has engaged in an intentional gamble and lost. The non risk taker has not gambled, but due to circumstances beyond her control she has developed a health problem. In an important way, then, the risk taker has chosen a different life from the non risk taker, namely, one that involves increased risks to health. The risk taker gambled with her health in the hopes of gaining some advantage (this might be anything from the pleasure of smoking, to a higher socio-economic status).

Dworkin may still insist that the distinction between option luck and brute luck is not a sufficiently relevant difference to override the risk taking patient's "right to equal consideration in treatment."[38] Putting aside for the moment that Dworkin invokes this right without ever spelling out its source or its full entailments, there is good reason to differentiate between the two patients. The risk taking patient has made an intentional gamble, one which she could have avoided.[39] The non risk taker however, took no such gamble and as such, could not have avoided his health problem. The relevant difference between the two health problems is that the risk taker's was, in a very real sense, preventable.[40] [41]

The second major problem with Dworkin's argument is that he does not

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[38] G. Dworkin 1981, 31

[39] As Dworkin points out, any risk taker may try to claim an excuse for his or her behavior, but for the moment I am operating with Dworkin's own set of assumptions that the risk was fully voluntary.

[40] Moss and Siegler 1991, 106

[41] Of course, it could be argued that if the risk taker had avoided the relevant gamble, she might have then suffered from bad brute luck and developed the exact same health problem she would have had she gambled. In this sense then, her health problem was unpreventable, since even if she had avoided the risk, she would still have gotten sick.

conceptualize the issue of treating risk taking patients as a being primarily a question about the right to health care itself. Dworkin's strategy is to focus on the move from causal-responsibility to liability-responsibility, and argue that in many cases the move cannot be easily made. In cases where the move is legitimate, Dworkin's strategy is to try to limit what exactly liability can entail for the risk taker. Along the way, Dworkin refers to an ill-defined right to equal consideration in treatment, but never flushes out what exactly is entailed by this right. Most importantly, Dworkin seems to just assume that this right is not particularly responsibility sensitive. On the other hand, when discussing whether risk takers should be liable for the cost of their care when that care is usually subsidized by the state, Dworkin seems open to the possibility of risk takers bearing at least some of the costs of their treatment. This suggests that the right to health care which justifies subsidizing citizens' treatment is at least somewhat responsibility sensitive. Dworkin however, does not offer any arguments to support either of these assumptions.

When we enquire whether it is justified to withhold treatment from risk taking patients, or whether it is justified to hold risk takers liable for the costs of their treatments, we are asking a question about the right to health care. Should we understand the right to health care as being responsibility sensitive? That is, can a citizen, through her actions, forfeit her right to receive adequate health care, or at least forfeit her right to have that care paid for by the state or by her insurance scheme? The answer to these questions depends heavily on how the right to health care is developed. If the right to health care is understood as following from a principle of utility, it is likely to have very different features from a principle that is formulated through an appeal to a highly choice

sensitive system of justice, such as that formulated by Ronald Dworkin or Eric Rakowski. In the case of a utilitarian account, the demand of maximizing overall welfare may well supercede any arguments for withholding treatment from risk takers. Under a highly choice sensitive model of liberal equality however, individual gambles made by agents will likely feature much more prominently in any deliberations regarding health care delivery. Similarly, if the right to health care is developed through an appeal to equality of opportunity, it may differ substantially from an account based on a pluralistic set of principles such as those put forward by Allen Buchanan, since Buchanan's principle of enforced beneficence may require the treatment of risk takers even if they are determined to risk their health.

Without answers to the challenges I have outlined above, Gerald Dworkin's arguments seem insufficient to adequately resolve the issue of how we should respond to the health problems of those who have taken risks with their health. I will now move on to my own position, beginning with my account of the right to health care, and to what degree it can be understood as responsibility sensitive.

Chapter 2

In this chapter, I will present the first half of my discussion on the right to health care. My focus in this section is on the principles that should be properly understood as underlying and motivating this right. There are, of course, far more accounts of the right to health care than I can reasonably consider in this chapter. As a result, I must limit my discussion to the two accounts I believe are most compelling[42]: the pluralistic argument offered by Allen Buchanan, and the equality of opportunity approach developed by Norman Daniels. I will begin by briefly discussing Allen Buchanan's theory, and offer some objections aimed at demonstrating its shortfalls. Next, I will give an account of Norman Daniels' theory, and offer several arguments that illustrate some concerns we ought to have about certain facets of his account of the right to health care. I will argue, however, that while we ought to have some concerns about Daniels' theory, it is the best account of the right to health care available.

Allen Buchanan's Pluralistic Theory

In response to what he takes to be the failures of utilitarianism and theories of distributive justice to account for the right to health care, Allen Buchanan develops his own pluralistic theory of the right. He argues that rather than the right following from a single universal principle of justice, such as the principle of equality of opportunity, the right to health care is best understood as following from the combined weight of several quite different arguments. Thus, he suggests that special rights to health care, harm-prevention, prudential arguments, and arguments for enforced beneficence are together

[42] For a discussion of these alternative accounts of the right to health care and their respective shortcomings, see Buchanan 1981.

sufficient to account for a right to a decent minimum of health care.[43] I will now briefly relate each of these four independent arguments, and offer an objection to Buchanan's claim that they completely account for the right to health care.

Buchanan's first major argument is from special rights. A special right-claim, in contrast to universal right-claim, restricts the right in question to certain individuals or groups. According to Buchanan, there are at least three arguments that would establish a special right-claim to health care for certain groups. The first is an argument from the requirements of rectifying past or present institutional injustices. For example, it can be argued that First Nations people are entitled to a certain core set of health care services owing to their history of unjust treatment by the Canadian government, on the grounds that this unjust treatment has adversely affected the health of the group. The second argument is from the requirements of compensation to those who have suffered unjust harm or who have been unjustly exposed to health risks by the actions of private entities. For example, those individuals who have suffered neurological damage from the effects of chemical pollutants released by a corporation would have a valid special-right claim to health care to treat that neurological damage. The third argument is from the requirements of compensation to those who have made exceptional sacrifices for the good of society as a whole. In particular, Buchanan identifies those who have been adversely affected through military service, though this could as easily apply to those who have been injured while working for emergency services (fire fighters, police, etc.).[44]

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[43] Buchanan 1984, 66
[44] Buchanan 1983, 67

The second major argument that contributes to Buchanan's account of the right to health care is based on the well accepted principle of harm prevention. According to Buchanan, the moral duty to prevent harm requires the implementation of public health services, such as sanitation and immunization, needed to protect the citizenry from certain harms arising from the interactions of persons living together in large numbers. The availability of these basic public health services should not vary greatly across different racial, ethnic, or geographic groups within society, since the moral principle of harm prevention assures equal protection from the harms these measures are designed to prevent.[45]

Buchanan's third argument is prudential, and emphasizes benefits rather than the prevention of harm. Buchanan here draws upon those arguments that suggest the availability of certain basic forms of health care make for a more productive labor force or improve the fitness of the citizenry for national defense. If these arguments hold true and the productivity and security of the country are in fact increased by the improved health of the citizenry, then this provides a pragmatic element to the right to health care.[46]

According to Buchanan, the final type of argument that contributes to the right to health care is based on a principle of beneficence.[47] He begins with an assumption he believes all reasonable persons, libertarians included, accept: there is a basic moral obligation of beneficence to those in need. While there are many traditional arguments for this obligation of beneficence, Buchanan draws upon Kant's account to illustrate the concept. In the second part of the Grounding for the Metaphysics of Morals, Kant offers an argument for the duty to aid those in need. His claim is that one cannot consistently

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[45] Buchanan 1983, 67-68
[46] Buchanan 1983, 68
[47] For an in depth discussion of Buchanan's views on the principle of beneficence, see Buchanan 1982.

will the universalization of the maxim of not aiding others in need, since to do so would be to deprive oneself of aid from others. He concludes that we are therefore duty bound to provide aid to those in need.[48] Buchanan argues that in a society such as ours, which has the technical knowledge to cure many diseases and heal most injuries, the principle of beneficence will require the allocation of resources for certain kinds of health care, for this will constitute an essential component of providing aid to the needy.[49]

Taken together, Buchanan believes that these arguments from special rights, harm prevention, prudential concerns, and beneficence are sufficient to account for a universal right to a decent minimum of health care. I do not believe, however, that Buchanan's argument is successful in offering a compelling account of the right to health care. The major problem with Buchanan's theory is that it does not offer an account of health needs as distinguished from other kinds of needs. While the principle of beneficence Buchanan adopts may require a duty to provide for some needs, it is unclear which needs he considers "health needs," and whether those needs that would be considered health needs are of a higher or lower priority than other needs. That is, Buchanan offers us no guidance as to how much of our resources ought to be directed to meeting citizens' health needs, whatever he thinks those are, as opposed to their needs for such things as for food and shelter. Without a concept of health, and a corresponding account of health needs, Buchanan's theory cannot offer us much real guidance in determining what his right to a

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[48] Kant (Trans. Ellington) 1993, 32

[49] While this requirement of beneficence could in theory be satisfied by voluntary individual giving, rather than state provided services, Buchanan points out that that this would be cold comfort if, for any of several reasons, voluntary giving were to falter. Buchanan goes on to explain some of the reasons why voluntary giving would likely fail to meet the requirements of beneficence, most notably the problem of assurance and the problem of coordination. He then offers two arguments that demonstrate why these problems are best addressed through enforced beneficence. While these arguments are very interesting in their own right, they are unfortunately not central to the discussion at hand. Buchanan 1983, 68-72

decent minimum of health care actually entails, and what sorts of services it would require us to provide.

If Buchanan were able to offer a theory of health needs, he would likely be able to account for most of the health services we believe should be provided to the public. Even if he were to do this, however, I believe that his theory would not provide the correct rationale for why we provide health services to those with disabilities. Buchanan's principle of beneficence would require that we offer health services to the disabled, because they would likely be identified as being in need. But this would seem to imply that we would be offering treatment out of a duty to charity, which I do not believe suits the intuitions of most of us, including members of the disabled community, as to why we provide treatment to those with disabilities. The responsibility to address disabilities is matter of justice, not of charity. We do have an obligation to provide care for people with disabilities, but it is not born out of Buchanan's principle of beneficence, but, as will become clear in the next section, it is instead rooted in Daniels' principle of equality of opportunity. We offer people with disabilities treatment and aids of various kinds in order to remove, as much as possible, any barriers impeding their opportunity to pursue their life goals.

Norman Daniels' Equality of Fair Opportunity Theory

Normal Daniels' account of the right to health care is best understood as an alternative Rawlsian approach. Unlike a more conventional Rawlsian approach,[50] he does not attempt to derive the right from the difference principle, nor does he appeal to a specific Rawlsian principle for allocating health care resources. Instead, Daniels makes

[50] An example of such an approach is described in Buchanan 1981, 222-227

the case for the right to health care by appealing to a more robust and inclusive Rawlsian principle of fair equality of opportunity.[51] Daniels' focus in this project is on distributive justice, and the various ways in which disease and injury can restrict people's normal range of opportunity to purse their life plans.

According to Daniels, an account of the right to health care must address two primary issues. The first is to explain and justify why many of us consider health care to be "special." That is to say, it must explain why health care needs should be given greater priority than the satisfaction of other preferences. Daniels believes that health care is indeed special, and his account of the right to health care is partially aimed at illuminating what it is about this right that gives it higher standing than other social goods. This is not an entirely straightforward process, however, because health care is not homogenous in function or effect. [52] Sometimes health care serves to extend life, while at other times it serves to reduce or eliminate pain and suffering. In other instances, however, the concept of 'health care' can be invoked in quite different ways, such as for cosmetic surgery.[53]

This brings us to the second issue that Daniels' account addresses, which is to distinguish between the more and the less important things health care does for us.[54] As Daniels points out, while the many functions of health care all aim at improving quality of life, "[not] all things that improve quality of life are comparable in importance: the

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[51] Daniels 1981, 154
[52] Daniels 1985, 107
[53] As we will see, it is in fact medical care that is not homogeneous in function or effect. Through Daniels' account, "health care" becomes restricted beyond our everyday use of the term to involve only those conditions that fit under Daniels' notion of health. Daniels does not himself distinguish between health care and medical care, but the distinction is an important one, as will become clear when discussing which types of care ought to be considered "health care".
[54] This is Daniels' wording, but as it is, it is somewhat inaccurate. As will become clear, his account allows us to determine which sorts of medical care are of special importance, and therefore ought to be labeled "health care."

way quality is improved seems critical."[55] For example, while an 'ear tuck' may improve someone's quality of life by giving them greater satisfaction with their appearance and improved confidence, this improvement in quality seems far less important than the improvement in quality that would obtain from a treatment that cures a life-threatening illness.

Daniels believes there is a central function of health care that is responsible for its special status among social goods, as well as for the greater importance of certain uses of health care over others. This central function is the maintenance of species-typical functioning, and the resulting effect on equality of opportunity. In different ways and to varying degrees, diseases and injuries impair our normal species functioning, which in turn reduce the range of opportunity we have to pursue the life-plans[56] we expect to find satisfying or happiness producing.[57] This is particularly problematic from the point of view of equality of opportunity, because disease and injury reduce the range of opportunity open to us, relative to the normal opportunity range for our society.[58] Daniels holds that since justice requires the protection of fair equality of opportunity (the position he inherits from Rawls), health care institutions ought to be governed by an appropriately extended principle of fair equality of opportunity.[59]

In order to draw Daniels' position into sharper focus, two concepts must be explained. The first is Daniels' conception of normal species-typical functioning, and the

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[55] Daniels 1985, 107

[56] This is a somewhat broader construal than Rawls, who focuses only on access to jobs and offices. Daniels 1981, 169

[57] Daniels 1981, 154

[58] Of course, as I mentioned in the previous paragraph, not all uses of health care are targeted at curing disease or injury. For Daniels, the importance of a particular type of health care is based on its effect on equality of opportunity. A life saving treatment has a profound effect on equality of opportunity, whereas an 'ear tuck' does not.

[59] Daniels 1985, 107

second is his notion of normal opportunity range for a society.[60] Daniels' introduction of species-typical functioning follows from his position on the nature of health and disease. In developing his account of health care needs, Daniels invokes a narrow "biomedical" model of disease and health.[61] Under this conception, health is defined as the absence of disease. Diseases are understood as "*deviations from the natural functional organization of a typical member of a species.*"[62] The identification of this natural functional organization is performed by the biomedical sciences, which must include evolutionary theory since claims about the design of the species and its fitness to meet its biological goals must underlie at least some of the relevant functional ascriptions.[63] While the process will be fairly similar between humans and animals, there will of course be added complications when dealing with humans, due to the complexities in trying to determine what would constitute species typical mental functions and functional organization. The biomedical model however, assumes, not unfairly in my opinion, that these complexities will be able to be accommodated adequately by modern cognitive psychology and neuroscience.

An example will help to clarify this concept of species-typical functioning and its relation to disease and health. If a woman were to suffer from a degenerative ear disorder that rendered her ears dysfunctional (impaired her hearing or balance), then she would be

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[60] In this section, I will be discussing Daniels' revised account of normal opportunity range, which was slightly reconceived in response to a volley of objections from Allen Buchanan. In my opinion, this revised account adequately addresses all of Buchanan's major criticisms. Buchanan 1981, Buchanan 1983, Daniels 1985

[61] Daniels borrows this model of health and disease from a series of articles by Christopher Boorse. Many attempts have been made to develop a definition of health, but none have found universal acceptance. In almost every case, the definitions have proven either too exclusive or vastly too inclusive. The biomedical model that Daniels invokes suffers from its own problems, which Daniels addresses (Daniels 1981, 155-156). Some examples of other definitions can be found in Callahan 1973 and Whitbeck 1981.

[62] Daniels 1981, 155

[63] Daniels 1981, 155

deviating from species-typical function, since ears have normal species functions and anatomy.[64] In this case her ear disorder would be considered a disease, due to its interference with her species-typical functioning. If, however, her ocular anatomy deviated only from a personal or social conception of beauty, it would not constitute a disease, since it would not interfere with her normal species functioning.[65]

Closely tied to Daniels' notion of normal species-typical functioning is his concept of a society's normal opportunity range. According to Daniels, "The normal opportunity range for a given society is the array of 'life plans' reasonable persons are likely to construct for themselves."[66] Of course, there are many variables present when trying to determine what range of life plans would be available to an individual in a particular society. Importantly, the range will be relative to key features of this society. Its stage of historical, economic, and technological development, as well as cultural facts about it, such as attitudes towards family and careers, will all contribute to the determination of a society's normal opportunity range. While the process of determining exactly what constitutes a society's normal opportunity range may be somewhat complex, Daniels' notion of species-typical functioning itself serves as a clear parameter relevant for defining the normal opportunity range. That is to say, a central component of the normal opportunity range is possessing species-typical functioning. Consequently, an impairment of normal functioning through disease constitutes a fundamental restriction on individual opportunity relative to the normal opportunity range.[67]

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[64] This designation would likely be disputed by advocates of deaf-culture.
[65] Daniels 1981, 157
[66] Daniels 1985, 107
[67] Daniels 1981, 159

Of course, no individual could ever have access to the entire array of life plans available within a society, since the portion of the normal range an individual has access to will always be limited by that individual's skills and talents. Health problems causing impairments of species-typical functioning restrict an individual's opportunity range relative to that portion of the normal range that the individual's particular skills and talents would ordinarily have made available to her. Daniels explains that, "The fair equality of opportunity principle is only intended to guarantee individuals their reasonable share of the normal opportunity range: the subset of the normal range their skills and talents make it reasonable for them to pursue."[68] [69]

To summarize, Daniels' position is that health care has a special status among social goods, because of its direct effect on equality of opportunity. Diseases cause impairments of species-typical functioning which in turn reduce individuals' shares of the normal opportunity range for their society. Daniels' principle of fair equality of opportunity requires us to provide health care services in order to maintain or restore individuals to species-typical functioning; thereby preserving the share of the normal opportunity range individuals would ordinarily have open to them. Daniels' right to health care will therefore include only those treatments that have a direct bearing on our opportunity range, and will exclude treatments for those conditions that do not impede our ability to pursue the life plans our normal range of skills and talents make available to us.

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[68] This is important, because it demonstrates that Daniels' account is not a leveling principle intended to pull all people down to a common denominator, nor pull all people up to an equal share of the very wide normal range. For Daniels, opportunity is equal in the sense that all persons should equally be spared certain kinds of impediments to opportunity.

[69] Daniels 1985, 108

I believe that Daniels' identification of equality of opportunity as central to the right to health care is correct. The primary reason we offer patients treatment for their health problems is that if their conditions remain untreated, they will be unable to pursue the normal range of life goals. Likewise, we use preventative therapies in order to reduce the chance that barriers to opportunity will arise at all. The demands of distributive justice ought to be understood as a central part of a proper account of the right to health care. As a result, my criticisms of Daniels' position are not aimed at undermining Daniels' overall theory, but rather are aimed at illustrating certain concerns I have about his particular account.

As I have described, Daniels believes that health services should be provided in cases where an individual's species-typical functioning is impeded so that they can no longer access their fair share of normal opportunity range for their society. Under Daniels' theory, if an individual's condition does not affect their opportunity range, it follows that any health care services required would not be included under the right to health care. Therefore, any treatments for health conditions not affecting an individual's opportunity range would not be covered by a state system of health care delivery governed by Daniels' principle of fair equality of opportunity. Yet there are undeniably health conditions that will not affect an individual's opportunity range, but will affect that individual's welfare in an unacceptable way. Daniels is unable to account for these instances, because they fall outside the very narrow scope of distributive justice within which his theory operates.

Let us imagine someone who suffers from some form of chronic pain.[70] [71] This pain is serious, but due to her high pain threshold the individual suffering from it can tolerate it sufficiently to carry on with her daily activities and career. While in constant discomfort, the pain obviously does not reduce her opportunity range, since her ability to pursue her life plans is not adversely affected.[72] Since her health condition does not affect her opportunity range, it would seem *prima facie* that her condition would not fall under those covered by Daniels' version of the right to health care. This is problematic, however, because the individual is clearly suffering harm due to her health condition. Intuitively, it seems obvious that any account of the right to health care must be able to accommodate health problems causing suffering as adequately as it accommodates those causing a loss of opportunity. The reason for this is that whatever normative theory one embraces, harm and suffering are morally problematic, even if an individual's income and social status are unaffected. As it stands, Daniels' theory does not seem to address cases such as the one I have described, which raises concerns about how complete an account of the right to health care it is. I will now consider some strategies Daniels could use to respond to this objection appealing only to equality of opportunity, and demonstrate why these responses would fail to adequately address the problem.

The first strategy Daniels could employ would be to argue that the sort of chronic pain I have described constitutes a deviance from normal species-typical functioning, and

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[70] The source of the pain could range from an old injury to a case of arthritis. The cause is unimportant so long as it is not a condition that is life threatening or debilitating. Also, while the case I discuss here involves physical pain, a similar argument could be offered for a case that involves mental suffering due to an illness such as anxiety, depression, or post-traumatic stress.

[71] Another sort of case would be someone dying of old age who is suffering a great deal of pain. According to Daniels, dying of old age is not a deviation from species-typical functioning. It would therefore seem that Daniels could not offer good reason for providing palliative care for this individual.

[72] While one might try to suggest that any significant pain of this sort would necessarily cause an impediment of opportunity, I believe this sort of position would be quite naïve. People suffer from all manner of conditions that do not affect their opportunity, yet cause them significant discomfort.

would therefore be treated, since the purpose of the right to health care as he has developed it is to maintain/restore species-typical functioning. This response fails on two counts. In the case of someone who is very old, and whose pain originates from natural organ failure, the pain being felt is not a deviation from function. The function of pain is to alert us to us to damage to our selves. Since the organs are failing due to natural causes, they are not deviating from species typical function. Likewise, the pain is not a deviation from species typical function, since it is performing its role of alerting the individual to the condition of her organs.

There will be other cases of pain, however, in which pain receptors may in fact be causing pain for no good reason. In such as case, the pain would constitute a deviance from species typical function, since it would no longer be functioning as an indicator of damage. This leads us to the second problem, which is that in such a case the essential connection to opportunity is missing. Within Daniels' framework, species-typical functioning has no inherent value. That is, normal human functioning is not preserved/restored for its own sake, but rather because of its effect on an individual's opportunity range. While Daniels considers species-typical functioning to be a central element of the normal opportunity range for a society, this particular aspect of human functioning would not be relevant to the normal range, since it does not actually impede opportunity. So even if we grant Daniels the premise that the absence of non-debilitating pain is an element of species-typical functioning, he can still offer no reason to treat the condition, since this instance of deviance from normal human functioning has no bearing on an individual's opportunity.

The second strategy Daniels could adopt in responding to my objection would be to expand his principle of equality of opportunity beyond the strict considerations of distributive justice to include protection from harm. This would be a reasonable move for Daniels to make, since the happiness people obtain from pursuing their life plans is clearly important to him,[73] and this happiness would be significantly reduced by the presence of physical or mental suffering. Daniels could, of course, simply introduce a principle of nonmaleficence separate from his principle of equality of opportunity in order to account for the moral importance of preventing suffering.[74] I do not believe, however, that Daniels would do this, because of his desire to account for the right to health care entirely in terms of equality of opportunity. Indeed, he criticizes Allen Buchanan's pluralistic account of the right to health care for being just such a "hodgepodge of principles."[75]

In accounting for the importance of harm prevention, the principle of equality of opportunity could be reconceived by Daniels as prohibiting barriers to opportunity for personal happiness/welfare,[76] as well as barriers to economic and social opportunity (which are themselves understood as means to happiness). Since pain and suffering constitute an obvious obstacle to attaining happiness/welfare, health care institutions would therefore cover not only those conditions that pose barriers to the pursuit of one's

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[73] Indeed, Daniels implies that the importance of pursuing one's life plans follows from the happiness that it is expected to produce. Daniels 1981, 154

[74] This approach involves the added complication of introducing a much wider theory of needs than is required by Daniels' focus on health needs.

[75] Daniels 1985, 106

[76] It is important to note that when I refer to welfare in this section, I am referring to what Ronald Dworkin identifies as *conscious state welfare* (one's subjective sense of well being and happiness), as opposed to *success welfare* (the degree to which one has succeeded in accomplishing one's life plans). R. Dworkin 1981,

life plans (economic goals), but would also include those conditions that would cause an individual pain or suffering.

This sort of response is problematic for two reasons. First, it constitutes a significant departure from fair equality of opportunity as conceived by Rawls.[77] Equality of opportunity is usually understood as insuring fair competition for social standing and resources. While prestige and resources are understood as means to increasing one's happiness, one's individual welfare itself is not typically considered to fall within the purview of equality of opportunity. This is a problem in that Daniels draws heavily on Rawls in developing his account of the principle of equality of opportunity. If he were to include opportunity for welfare within this principle of equality of opportunity, he would need to draw upon a different source to motivate the principle.[78]

The second problem Daniels would face were he to try to account for the prevention of suffering using his principle of equality of opportunity is far more difficult than the first. By expanding equality of opportunity to include opportunity for welfare, Daniels' principle would become far too inclusive, and as a result it would become the sort of "leveling" principle he himself criticizes.[79] The inclusion of welfare would make the principle too expansive, because it would require health care institutions to provide services for conditions well beyond the scope of what Daniels has defined as health care needs. Let us consider for a moment the case of someone who is painfully ugly, and is miserable because of it. This person's appearance is clearly a major barrier to their ability to achieve happiness. It would seem to follow that the expanded principle would require

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[77] Rawls 1971, 73

[78] Arneson's account of Equal opportunity for Welfare might provide the necessary foundation for this revised principle. Arneson 1988

[79] Daniels 1985, 108

health care institutions to provide cosmetic surgery to improve the ugly patient's appearance and therefore restore his opportunity for happiness. This is problematic however, since performance of cosmetic surgery for the purpose of conforming to social standards of beauty would seem to fall outside of what we typically consider to be a legitimate health care need.[80]

In response to this challenge, Daniels would most likely insist that like the more conventional principle of equality of opportunity, the expanded principle would only guarantee individuals the share of the normal opportunity range for welfare that their skills and talents make it possible for them to obtain. Health care institutions would therefore be under no obligation to provide services such as cosmetic surgery for the ugly, because they are required to eliminate only certain kinds of barriers, namely those that result from disease or disability. While this restriction makes sense when applied to the conventional principle, I believe that it fails to apply to the expanded principle of equality of opportunity for welfare, because it would bring with it an unacceptable arbitrariness.

In general terms, the normal principle of equality of opportunity is concerned with assuring fair competition for advantageous positions within a meritocracy.[81] Under such a principle, one's skills and talents can be understood as placing legitimate limits upon one's opportunity range, since those skills and talents are relevant in determining how well qualified one is for a given position. The expanded principle of equality of opportunity, however, differs in an important way from the normal principle. While the

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[80] While this example focuses on appearance, there are a multitude of factors that can restrict people's opportunity to achieve happiness, and a number of these could be removed through appropriate health care services.

[81] Obviously this is a substantial simplification of equality of opportunity, but it is sufficient to ground the present discussion without distortion.

expanded principle should be understood as governing fair competition for advantageous social positions, it is also aimed at assuring individual opportunity to attain personal happiness. While individual skills and talents are relevant in determining how much an individual merits a given social position, those same skills and talents are *not* relevant in determining whether or not one should be able to experience personal happiness.

To illustrate the above distinction, let us consider the case of the (socially viewed) 'ugly' individual we discussed earlier. Imagine that this person wished to become a fashion model. In determining whether or not this individual would succeed, obviously the social attractiveness of the person's appearance will be very relevant, since beauty is a requirement for fashion models. While the 'ugly' individual will obviously not succeed in his desire to become a famous model, the competition would still have been fair, since it would have been judged on relevant merits. In the case of this individual's personal happiness, however, there is no reason to think that the fact he is ugly makes him less deserving of happiness than a person who is not ugly. The individual's ugliness is an arbitrary factor that creates a barrier to his opportunity for happiness, which would clearly be objectionable from the point of view of the expanded principle of equality of opportunity.

My second concern about Daniels' position arises from his assertion that "Health-care institutions have the *limited* function of maintaining normal species functioning: they eliminate individual differences due only to disease or disability."[82] As I mentioned earlier, Daniels understands diseases as conditions that cause deviations from species-typical functioning. Daniels himself points out that an unwanted pregnancy would not qualify under his theory as a disease, since it does not constitute a deviation from normal

[82] Daniels 1985, 109

human functioning.[83] While pregnancy, unwanted or not, is obviously not a disease, the fact that Daniels maintains that the limited function of health care institutions is to treat disease and disability means that unwanted pregnancies[84] will fall outside of the scope of publicly funded health care institutions.[85] As a result, should a pregnant woman wish to abort her fetus, she would be unable to have that service provided through her right to health care.[86]

This conclusion strikes me as odd, since an unwanted pregnancy is a medical condition that can have significant effects on a woman's opportunity range, regardless of whether or not it affects her species-typical functioning. If one accepts the moral permissibility of abortion, one would expect women to have access to appropriate medical technologies in order to insure that they do not suffer from unwanted barriers to their opportunity. Daniels could try to argue that his theory would support the funding of treatment for unwanted pregnancies by suggesting that the risks associated with abortion are sufficient to require the participation of health care institutions. The actual risks associated with modern pharmaceutical early-term abortions, however, are now low enough that they are often performed by women in their own homes (using appropriate pharmaceuticals prescribed by physicians). While Daniels might be able to make the case that high-risk, late-term abortions should be publicly funded, his case for ordinary

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[83] Daniels 1981, 157

[84] A pregnancy that is wanted also appears *prima facie* to fall outside of the scope of health care institutions, but Daniels could fairly easily account for their inclusion due to the substantial risks associated with childbirth and the importance of preventative care in preserving opportunity.

[85] Daniels confirms this in a footnote, where he explains that non-therapeutic abortions do not count as health care needs under his account. Daniels 1981, 157

[86] Unwanted pregnancy is just one example of a health condition that fails to meet the narrow criteria of disease that Daniels has invoked. A few examples are warts, psoriasis, and eczema. All of these are medical conditions, though none of them actually meet Daniel's criterion of disease by impacting species-typical functioning.

abortions being funded by an appeal to the right to health care would be weak at best, since low-risk abortions would seem to fall outside of the scope of health needs.

Both the concerns I have just expressed spring from the apparent inability of Daniels' theory to account for certain medical needs that many believe are of moral importance and therefore ought to be accounted for by an adequate theory of the right to health care.[87] Daniels' theory takes health to be species-typical functioning, and it is this aspect of the model that excludes certain important medical needs from the scope of health needs. In order to account for these medical needs as part of the right to health care, it may be tempting for some to simply reject his model of health in favor of a more expansive definition. This, I think, would be unwise, because it would probably require us to adopt the bizarre premise that such things as unwanted pregnancy are unhealthy or even qualify as diseases.

Daniels is aware that there are other important social goals, some protected by right claims or other claims of need, which may require the use of medical technologies.[88] He is not opposed to the use of medical technologies to reach these other social goals; he just does not believe that they are properly understood as matters of health. Unfortunately, Daniels does not elaborate much on these other rights or needs, so it is difficult to know exactly which social goals he has in mind. For the moment, however, I am willing to give Daniels the benefit of the doubt, and assume that he could, given his

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[87] The belief that medical needs ought to be accounted for under a right to health care may follow from a general confusion within the public debate about health care. In the public debate, "health care" is usually taken to refer to all those services provided by our health care institutions. Daniels gives us good reason to think that not all of these services are properly understood as health services, even though they are all medical services. It may be that what we need is not just an account of the 'right to health care,' but an account of the 'right to medical services,' of which health services will be a major part. Such an account would have to prioritize certain medical needs over others, which would require the development of an involved theory of needs. This sort of approach might clear up some of the confusion present when discussing what "health" services ought to be provided to the public.

[88] Daniels 1981, 173

reference to the importance of other social goals, account for the importance of treating the sorts of cases (chronic pain, unwanted pregnancy) that I have discussed in this chapter.

Daniels' account has several key strengths, which I believe justify our adoption of his model for the discussion at hand. Daniels offers us a clear definition of health, which allows us to distinguish health needs from other sorts of needs. His appeal to equality of opportunity offers a coherent justification for prioritizing health needs, and ascribing health care as a right. While he does not explicitly spell out how he would deal with important cases such as those I have discussed; we can make the safe assumption that his theory could in principle address them, since even though they are not fully developed, the theory does contain the necessary mechanisms to account for the provision of medical services that do not meet his strict guidelines for health services.

In this chapter, I have discussed two accounts of the right to health care. I have suggested that for several reasons, Allen Buchanan' theory fails to provide a compelling account of the right. Norman Daniels, on the other hand, provides us with an account that is both clear and coherent. While I have expressed some concern that Daniels' theory encounters difficulty with certain cases, I have argued that my concerns could likely be addressed by Daniels' acknowledgement that other social goals may justify the use of health care technology for purposes other than the maintenance of species-typical functioning. I will now turn to the second half of my discussion of the right to health care, which is the degree to which the right is responsibility sensitive.

Chapter 3

In this chapter, I will present the second half of my discussion on the right to health care, which focuses on the degree to which the right to health care should be understood as responsibility sensitive. As I explained in the previous chapter, the best account available of the right to health care is Norman Daniels' theory, which is based upon the principle of equality of fair opportunity. My discussion in this chapter will consist of two parts. The first part of the discussion focuses on equality of opportunity, and the reasons why it is usually understood to be responsibility sensitive. I will argue that, given that the right to health care is based upon such a principle, it should be understood as responsibility sensitive. The second part of my discussion focuses on the conditions required for the responsibility sensitivity of the right to be activated. I will offer an account of acceptable risk for patients, aimed at illustrating which sorts of risky behaviors are sufficient to qualify for an exception to the right to health care.

Responsibility Sensitivity

In political philosophy, responsibility sensitivity usually refers to the degree to which a political theory is sensitive to the choices people make. Often, this choice sensitivity is in reference to the degree to which a political theory allows for inequalities that arise from the different choices people make within a given society. A highly responsibility sensitive theory, such as Eric Rakowski's,[89] allows for greater inequalities to arise due to individual choice than a less responsibility sensitive theory, such as

[89] Rakowski 1993

Elizabeth Anderson's.[90] In the current context, responsibility sensitivity refers to whether or not one's right to health care can be affected by one's choices. If the right to health care is understood as responsibility sensitive, then inequalities of opportunity that arise due to self-inflicted diseases would fall outside of those barriers to opportunity covered by the right.[91]

Before addressing the responsibility sensitivity of Norman Daniels' account of the right to health care, I will briefly consider how Allen Buchanan's theory would respond to this same issue in order to illustrate how one's account of the right determines the degree to which the right is understood as responsibility sensitive. I believe there are two reasons to think that Buchanan' theory might not be sensitive to individual responsibility. The first reason arises from Buchanan's prudential argument that holds that since health care can contribute to the productivity of the populace, it ought to be provided. On the surface, it would seem that this prudential argument would not be responsibility sensitive, since its goal is to increase the productivity of the populace, and this will be probably be best accomplished by the provision of health care for all health conditions, regardless of their origin. After all, productivity will be reduced as much by a self-inflicted health condition as it would from an ordinary health condition.

Of course, another prudential argument, this one based on deterrence, could be offered in order to counter this point. It might be suggested that not offering treatment for self-induced health conditions will provide a strong deterrent to those who would take risks with their health, and given the high costs of providing health care, this deterrent

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[90] Anderson 1999

[91] To use the terminology introduced by Gerald Dworkin, the question of responsibility sensitivity is about whether or not one can be held responsible in the liability sense for health problems arising from one's risky behavior. If the right to health care is responsibility sensitive, then an individual can be considered liable for the costs of his own care, when he can be shown to have clearly caused his own health problems.

effect is desirable. The problem with this argument is that it relies on the assumption that not providing care will actually constitute a deterrent strong enough to more than compensate for the loss of production that would occur due to untreated, self-inflicted health problems. It is hard to say for sure how effective such a deterrent would be in a given society, but there is at least some reason to suspect that the effect might not be strong enough to justify the loss of production. After all, for a variety of reasons, many people continue to smoke even though they know it may well kill them, even with proper medical treatment. This by no means proves the deterrent argument would fail to require responsibility sensitivity, but it does make it an empirical, case by case issue, insofar as proponents of deterrence would have to prove that it would have the positive effect they say.

Alternately, one might argue that the prudential argument could require responsibility sensitivity in order to help manage the costs of treating self-inflicted health problems. Like the deterrent argument, this position turns on the issue of whether the negative effects of any untreated diseases will outweigh the beneficial effects of such a policy. The most effective version of this argument would likely propose some sort of mandatory insurance market for risk takers, which would be affordable enough to allow even the financially poor to be able to participate, thus reducing the number of untreated diseases detracting from productivity and security. While such a policy may be possible, the effectiveness of this argument, just like the deterrence argument, relies on the assumption that on aggregate, the benefits to productivity and security would outweigh the reductions caused by such policies; if they do not, then the case for responsibility sensitivity would suffer.

The second reason Buchanan' theory may not be responsibility sensitive is based on the principle of enforced beneficence. Ordinarily, beneficence is understood as an imperfect duty, which means that the amount of aid given and who the aid is given to are a matter of choice for the one rendering the aid. In an individual situation, in which the benefactor may use discretion in deciding whom to aid, it would be acceptable for the benefactor, as a matter of personal discretion, to choose to aid only those who had not contributed to their own health problems. In the collective situation that Buchanan envisions, however, the requirements of enforced beneficence do not allow individual use of discretion, since the project of beneficence becomes an enforced, collective action.[92]

Since the ordinary discretion allowed by imperfect duties will not apply in the collective case, the issue of whether aid may be withheld from risk takers would rely upon one's interpretation of the principle itself. One such interpretation would be that the principle is not in itself responsibility sensitive, because it would be irrational to will the universalization of a maxim in which beneficence only applied to those who had not contributed to the development of their own conditions. If one were to will such a maxim, then one would be depriving oneself from the aid of others in cases in which one had simply made a bad choice. Indeed, if one had made a bad gamble and had lost, one may truly need and want aid from others. If this is so, then one would wish the maxim behind the principle of beneficence to be blind to responsibility for the need.[93]

I should note that my comments on Buchanan's arguments are not meant to prove beyond a doubt that his theory is not responsibility sensitive, rather they are only

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[92] The reasons for this are tied up in Buchanan's arguments regarding collective action problems in the context of discharging imperfect duties. Buchanan 1984, 70-75

[93] This is, of course, is only one possibility of how the principle could be interpreted. An alternative would be argue to that one would want to will a responsibility sensitive maxim, because one might want to live in a world with high levels of risk.

intended to show that there is some reason to think that his theory might be insensitive to personal responsibility. In doing so, my intent was only to demonstrate how significant an influence one's theory of the right to health care can have on one's deliberations about responsibility for health problems. As I argued in the previous chapter, Buchanan's theory is not the best account available of the right to health care. I will now turn to consideration of Norman Daniels's theory, which I will argue is clearly responsibility sensitive.

In determining the degree to which the right to health care should be responsibility sensitive, we must examine the principle of equality of fair opportunity that underlies it. The purpose of equality of opportunity is to remove arbitrary barriers to opportunity, so that our successes and failures are determined by our choices, rather than our circumstances. If one is pursuing a personal ambition, equality of opportunity is intended to insure that one's success is determined by one's performance, rather than by arbitrary factors such as one's race, sex, or socioeconomic background. To use Ronald Dworkin's terminology, which I introduced in chapter 1, equality of opportunity is intended to protect us from the effects of brute luck. Our race, sex, and sexual orientation, as well as society's attitudes towards these elements of personal identity, are all effects of brute luck, since they are not the results of deliberate gambles we have made. Conversely, our current socioeconomic status is, at least in principle, the product of option luck, since to some degree it is the result of deliberate gambles we have made.[94] Equality of opportunity is intended to mitigate many of the effects of luck that are not the

[94] Such gambles might include the decision to pursue this career rather than that one, or to gamble one's money on potentially lucrative, but risky, investments.

products of deliberate gambles, so that our lives are governed as much as possible by the results of those gambles we do intend.

In the context of health, Daniels explains that diseases constitute barriers to opportunity, since they impair our normal species function. Equality of opportunity therefore requires the treatment of health problems, so that one's ability to pursue one's life plans is not impeded. The purpose of health care is to insure that one's success or failure in meeting one's goals is determined by one's choices,[95] rather than by the diseases from which one suffers. Explained using Ronald Dworkin's terminology, the purpose of Daniels' health institutions is to treat those diseases that are the results of bad brute luck, so that one's life is governed only by the results of one's option luck.

So, the purpose of the right to health care, which is based upon the principle of equality of fair opportunity, is to treat those diseases that pose arbitrary restrictions upon one's opportunity range. Treatment must be offered so that one's life will be governed by the effects of one's option luck, rather than the effects of one's brute luck. This brings us to the central issue of the thesis: those health conditions that are the product of deliberate gambles we have taken with our health; health problems that are the result of option luck, rather than brute luck. It seems clear that the right to health care would not apply to health conditions that arise due to one's deliberate choices. Health problems arising due to one's bad *option luck* fail to fall under the scope of a right designed to protect us from the effects of bad *brute luck*. After all, the purpose of the right to health care, as it is formulated by Daniels, is to remove arbitrary barriers to opportunity that restrict one's ability to pursue one's life goals; it insures that one is free from diseases so

[95] This assumes that equality of opportunity is applied throughout society; not just within health care institutions.

that one's life is governed as much as possible by the choices one has made. Auto-induced health problems are not arbitrary, however, since they are product of one's choices.

It is, of course, undeniable that health problems resulting from voluntary health risks will impair one's species-typical function, and will, as a result, reduce one's range of opportunity. It might be argued then, that the principle of equality of opportunity would require auto-induced health problems to be treated, due to their negative effect on their victims' opportunity ranges. As I stated earlier, however, the purpose of equality of opportunity is to insure that as much as possible one's success or failure is the result of one's choices. If a health care institution were to provide treatment for an auto-induced health condition, it would essentially be mitigating the degree to which one's life is actually governed by the consequences of one's choice. Were it to do so, it would seem that the principle would be self-defeating, since it would be placing barriers on the very thing that it is meant to protect.

To further illustrate this point, consider the analogous case of a person who invests her money on the stock market with the hope of increasing her wealth. If she suffers from bad option luck, and loses a large sum of her savings, there is little doubt that her opportunity range may be impeded. The principle of equality of opportunity, however, would not require society to reimburse her for her loss, hence restoring her full opportunity range, since the purpose of the principle is to insure that she is able to make the choice to gamble, and that her success or failure will be determined by the consequences of that gamble.

For the reason I have just described, the right to health care is, in principle, properly understood as responsibility sensitive. That is, inequalities of opportunity that arise due to voluntary health risks fall outside of the scope of the right. The right to health care governs which services ought to be provided to the public as a matter of justice. The consequence of the right being responsibility sensitive is that treatments for health conditions arising from voluntary risky behavior will fall outside the range of treatments whose costs are covered under a national health care system. The fact that the costs are not covered, however, does not imply that risk taking patients ought to be denied treatment for their conditions. Rather, it implies only that patients who take risks with their health ought to be liable for the costs of their treatments.

As I discussed briefly in chapter 1, there are several different methods by which risk taking patients could be held liable for the costs of their treatments. One such method might involve the establishment of private, market based health care institutions which offer the same services as public institutions, but in which risk taking patients pay for the full cost of their treatments. Another such method would involve a publicly funded system in which risk takers simply pay higher taxes in order to offset the increased costs of their care.[96]

Before moving on, I should make a brief note on the difficulty in establishing the cause of a given disease. The precise causal web that contributes to the genesis of an illness is rarely entirely clear, and as a result, it is often difficult to determine whether a

[96] Daniels does not elaborate on exactly how much of Rawls' theory he is committed to, but it is important to note that Rawls takes equality of fair opportunity to naturally lead to the difference principle. If Daniels were to commit himself to Rawls's difference principle, then I think it likely that he would probably conclude that any inequalities arising from the responsibility sensitivity of the right would have to be structured in such a way as to be beneficial to the worst off in a society. This would in all likelihood prevent a system in which a risk taking patient would have to bear the entire costs of her treatment, since such a practice would hardly benefit those of the worst off who take risks with their health (most of whom could probably not afford any treatment).

particular illness is primarily the result of a patient's risky behavior, or some other factor over which the patient had no control. One may take risks that might not be thought to be the primary cause of one's health problem, even if the same risk might have caused the same problem in another individual. For example, while smoking is a strong contributing condition to heart disease, it is certainly conceivable that a smoker might have developed heart disease not primarily due to smoking, but instead due primarily to genetic makeup. As I described in chapter 1, Gerald Dworkin brings up this point in order to undermine the degree to which risk takers can be held liable for the costs of their care.[97] Dworkin's rationale for this is that if there was little or no causal connection between one's behavior and one's health problem, then one cannot be determined to be culpable for that health problem.

One might argue along similar lines, and suggest that my account of responsibility sensitivity depends on the assumption that a strong causal connection exists between a given risky behavior and the corresponding health problem. If a given risky behavior, such as smoking, was shown to have made only a minor contribution to the development of heart disease in a particular individual, one might argue that the heart disease was primarily the product of an arbitrary factor (the person's bad genes), rather than a deliberate gamble (their choice to smoke). One might further argue that the individual's heart disease ought, therefore, to be covered under the right to health care. Given the difficulty of unraveling the causal web behind most health problems, one might argue that it would be very difficult to make any assessments of liability for health problems, since one would have to prove that a given health problem was the primary cause of a given illness.

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[97] G. Dworkin 1981, 31

In determining to what degree risk takers can be held liable for their health problems, Dworkin focuses on culpability, which can only be established if there is a clear and appropriate causal connection between a given behavior and the corresponding health problem. I have argued, however, that liability for the costs of one's care can be established if one's health problem can be shown to be the result of a risk, an intentional gamble, that one has taken. The concept of risk interprets the uncertainties of causation as probabilities. As a result, it is not necessary to ask to what extent a given behavior caused a particular health problem. A health risk contributes to the development of a health problem by increasing the probability that the health problem will develop. To establish liability, it is enough that we be able to demonstrate that an individual engaged in a particular risky behavior, and thereby significantly increased her probability of developing the corresponding health problem. In the case of the smoker who has a genetic predisposition to heart disease, we need not demonstrate that her smoking was the primary cause of her illness. Instead, we can say that her disease is a consequence of her smoking, since it was her smoking that increased her already high probability of developing heart disease.[98]

While I have argued that the right to health care is responsibility sensitive in principle, in practice there are several important factors in determining whether the responsibility sensitivity of the right ought to be activated in any given case. For

[98] This point is relevant to another topic that I have not discussed; the issue of liability when we are not the only ones to have gambled with our health. Other parties sometimes take gambles with our health. Take the case of an individual who smokes a great deal of cigarettes, but also lives next to a pulp and paper mill that releases significant carcinogenic pollutants into the individuals' breathing air. If this individual develops lung cancer, it may be due to the combined risks created by smoking and breathing in the pollutants. To assign liability for the costs of treatment in this sort of case, it would not be necessary to determine whether the smoking or the pollution made a greater contribution to the development of the illness. It would be enough for us to establish that the smoking and the pollution both increased the probability that the individual would develop the disease

example, if one has taken a risk with one's health, but that risk was involuntary, any resulting health problem would seem to be more a product of brute luck than of option luck. In such a case, the risk should be considered acceptable, and therefore there is good reason to think that any treatment required would be covered under the right to health care. I will now turn to the second part of my discussion in this chapter, in which I address these various factors through an account of acceptable risk.

Acceptable Risk

By acceptable risk, I refer to those health risks that for one reason or another we believe people should be able to take without activating the responsibility sensitivity of the right to health care. I will argue that there are two major ways in which a health risk may be considered acceptable. First, a risk may be considered acceptable if it can be shown to not be fully voluntary. Second, a risk may be considered acceptable if it can be understood, for a number of reasons I will explain, to be "normal," or non-excessive.

As I discussed in the first chapter, the line between cases of option luck and brute luck is not always clear. This is relevant to the discussion of acceptable risk, because the right to health care covers diseases that are the results of brute luck, but not those that result from option luck. If a risk is not fully voluntary, then any health problems resulting from the risk will be at least partially the effects of bad brute luck, rather than strictly the effects of bad option luck. If a risk taken by an individual was not a deliberate, voluntary gamble, then the right to health care should cover any health problems resulting from the risk, since these will be the result of brute luck.[99] There are

[99] This assumes that the results are primarily the effects of brute luck. The precise degree to which a particular piece of luck is gauged option luck or brute luck will have to be determined on a case by case basis.

at least two reasons why a risk may be considered involuntary: the risk may not have been taken deliberately or the risk may have been taken due to lack of alternatives.

For a gamble to be fully voluntary, it must be made deliberately. If an individual does not know that he is in fact making a gamble, then we cannot say that he has deliberately taken a risk. He may have taken a particular action deliberately, but if he was unaware that this action involved risk, it would be inappropriate to say that he had deliberately made a gamble. This is relevant to the case of health risks, because certain individuals who have taken significant risks with their health may not have been aware that they were in fact taking risks. The most obvious group of risk takers to whom this would apply is smokers and former smokers who began smoking before the hazards of cigarettes were well known.[100] While we now know that smoking cigarettes can cause health problems ranging from cancer to strokes, at one time cigarette companies advertised their cigarettes as "Recommended by Doctors." Individuals who smoked during this period did take significant risks with their health, but these risks cannot be understood as voluntary, since the risks were not taken deliberately. People did intend to smoke, but they did not know that by smoking, they were in fact risking their health. Had they had the knowledge we now have, it is likely that many of those individuals would not have voluntarily risked their health by smoking cigarettes.[101]

There is, of course, a sharp contrast between those who began smoking when the dangers of cigarettes were not well known, and those who begin or continue to smoke

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[100] In fact, it would appear in hindsight that the hazards of smoking were well known by cigarette companies long before these companies admitted the dangers to the public. This has been the basis for a number of lawsuits in recent years. If this is true, then it might follow that in the case of smokers who smoked during this period of deception, the liability for subsequent health care costs would fall upon the cigarette companies, since they would have been taking deliberate gambles with smokers' health.

[101] Of course, it safe to assume that some portion of those smokers would have continued to risk their health, since people continue to smoke today, even though they know the full risks.

now. Current smokers should be well aware of the hazards posed by smoking, since they are currently printed on every package of cigarettes sold in Canada. It would be comical to suggest that a new smoker is not taking a deliberate risk with his health when his cigarettes come out of a box with the words "Cigarettes can kill you" printed on it.[102] In the case of cigarette smoking, lack of a deliberate gamble could only reasonably be claimed by individuals who started smoking prior to the time when the hazards of smoking become well known to the public.[103] In the case of these individuals, there is good reason to think that any health problems arising from their smoking are not the product of deliberate gambles, and as a result, those health problems should be covered by the right to health care, since they would be the products of bad brute luck, rather than bad option luck.

While I have discussed only the case of smokers who did not gamble deliberately, other groups of risk takers might be able to make similar cases for their own risky behaviors. One such group might be those AIDS sufferers who contracted HIV through intravenous drug use or unprotected sex before knowledge of the disease or its methods of transmission had become common knowledge.[104] Another group might be those who contracted type II diabetes due to poor eating and lack of exercise before the link between

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[102] Unless, of course, the individual is illiterate.

[103] Some might claim that while those who smoked during the period of ignorance regarding the harmful effects of cigarettes should be counted as having not gambled deliberately, those who started to smoke during this period, and then continued to smoke after it, ought to be understood as having made a deliberate gamble. This leads quite naturally the murky issue of addiction. I do not wish, for the moment, to get bogged down in a messy debate on the nature of addiction. For the moment, I will only say that addiction seems to constitute a very heavy, though not absolute, influence on behavior. If someone knew the dangers before they started smoking, then it might be reasonable to hold them responsible for their health costs, even if they are addicted, since they knowingly ran the risk of addiction. But if someone was ignorant about the dangers, including the danger of addiction, then we should probably say that their continued smoking is not fully deliberate, since they did not deliberately run the risk of addiction.

[104] This group is now quite small in developed nations, since many of those who fit this description have died over the past two decades. In less developed nations, however, there is still widespread ignorance to the hazards of many activities such as unprotected sex and smoking.

these factors was established by medical science. New groups of risk takers will probably be discovered as medical science progresses and unearths new threats to our health. In all likelihood, those who are first discovered to be taking risks by engaging in these activities would likely qualify as those who had gambled, but not done so deliberately.[105]

The second reason one may be understood as having gambled involuntarily is if one lacked alternatives to the risky behavior. If one lacks any option other than to take a gamble, then one cannot be said to have gambled voluntarily, since one had no choice. In such a situation, any health problems resulting from such risks would be the products of brute luck, and as such, would fall within the scope of the right to health care. The most prominent group of risk takers who would likely fall within this category are those of lower income whose eating habits are shaped largely by what they can afford.

Currently in North America, nutritious, healthy food is much more expensive than the highly processed, low nutrition-value foods that have become staples in lower income households.[106] These processed foods tend to be lower in protein and vitamins, and

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[105] There is another sort of case in which one's gamble might be thought to have been taken with a diminished level of deliberateness. This would be the type of situation in which one intended to gamble, but had no accurate sense of the odds, and therefore took a much more serious gamble than the one intended. An example of this sort of scenario would be someone who has been misled by the advertising for a particular product, such as alcohol. Advertising tends to present a very one-sided portrayal of a product. In the case of alcohol, advertising tends to stress the fun, sophistication, and sex appeal that people have from consuming it. Not included in most advertising is an equally compelling portrayal of the risks associated with excessive consumption of alcohol. It is not that the risks are unknown to the public, but only that the case for the positive aspects of the product is presented in a vastly more compelling way.

People are usually quite bad at assessing risk in their own lives, and advertising for risky products can exacerbate this. As a result, people may have a very poor grasp of the odds of the gamble they are making. This will be especially true in the case of minors, who have proven highly susceptible to advertising, and tend to underestimate the risks posed by many activities. Such risk takers are making gambles, but not necessarily the ones they thought they were making. In a sense, their gambles are deliberate, since they knew to some degree that their activities involved risk. Their actions do not seem completely deliberate, however, since there was no intention to take on the higher level of risk.

[106] Some might claim that there are healthy foods that are as affordable, if not more so, than junk food. In some cases, this is quite correct. There are junk foods, such as pizza or potato chips, which are relatively

higher in sugars, fats and salt, than the non-processed foods that those of higher income can afford. The development of type II diabetes is linked with obesity, which is often caused by the over-consumption of fatty, sugary foods. While those who cannot easily afford good quality food do deliberately consume these processed foods, they cannot be said to make this gamble fully voluntarily, since due to their income level, they have few available alternatives. Essentially, they have little choice but to gamble with their health.[107]

There are those of higher income that choose to eat poor quality food despite their ability to afford more nutritious alternatives. These individuals, however, could not claim that their conditions ought to fall under the right to health care, since they had access to alternatives, but chose to risk their health anyway.

Some might suggest that those of lower income have made a series of choices that have resulted in their financial poverty, and their resulting inability to afford good food is a direct result of these choices. If this were true, any health conditions resulting from poor nutrition would fail to fall within the scope of the right to health care. I think, however, that this sort of reasoning is problematic, since it ignores the blatant injustices that shape the opportunities available to those born into households of lower income.

The second major reason a risk may be thought of as acceptable is if it is considered to be "normal." [108] Normal risks are those voluntary risks we think people ought to be able to take without activating the responsibility sensitivity of the right to

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expensive in comparison to healthier foods. In general however, staple foods that are processed are less expensive than foods that are not. This is especially true in the case of restaurants. In many cases, fast food has become far more available, and affordable, than healthier alternatives.

[107] Of course, some of these individuals would still have gambled with their health, even they had alternatives.

[108] From this point on, I will refer to "normal" risks as just *normal risks*, and "abnormal" risks as *excessive risks*.

health care. These risks are voluntary, and as such any health problems arising from them would be considered the products of option luck, which means that under normal circumstances they would fall outside the scope of the right to health care. If we consider the risk normal, however, we do not wish, either out of considerations of justice or for pragmatic reasons, people to be held liable for the costs of their care, even though these costs are the result of this normal risk.[109]

Almost every voluntary action we take poses some level of risk to our health,[110] yet it is unlikely that all of these various actions ought to result in the activation of the responsibility sensitivity of the right to health care. That we take some risks to be normal, and therefore acceptable, is obvious. No one could reasonably propose that we hold people liable for the costs of their health care if they are engaging in what we think of as a normal activity. One of the clearest examples of this is the case of driving a motor vehicle. Driving is a very risky activity. Further, for most of those who engage in it, it is entirely voluntary. Strictly speaking, any health problems arising from driving are the products of option luck, and therefore the risk takers could in principle be held liable for the costs of any required treatments. Yet I think this practice would clash with the intuitions of many. The reason is that the risk seems acceptable, because it is considered normal.

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[109] Health problems arising from involuntary risks do not engage the responsibility sensitivity of the right to health care, because the responsibility sensitivity only applies to deliberate gambles. That is, the responsibility sensitivity of the right is only engaged by health problems arising from bad option luck. Here, the responsibility sensitivity is not thought to engage for a quite different reason. I am not suggesting that health problems arising from normal risks are the products of brute luck. Nor am I relying here on a distinction between two kinds of option luck, one which would activate the responsibility of the right and the other which would not. Health problems arising from normal risks are the products of voluntary gambles, and therefore are the products of option luck. The responsibility sensitivity of the right is not activated in instances of normal risk because if it were to be activated, and liability were to be assigned, it would be problematic from the point of view of justice, or pragmatic reasons.

[110] Even actions as commonplace as living for 2 months in an average stone or brick building involve a miniscule risk of cancer due to natural radioactivity. Fischhoff 1981, 81-82

One reason why a risk such as driving may be considered normal is if it is determined to be critical to equality of opportunity. Such a risk would be considered normal, because it would need to be taken by nearly everyone if they wish to pursue their fair share of the normal opportunity range for their society. Equality of opportunity is intended to insure that people ought to be able to obtain their fair share of the normal range. If assigning liability for health care costs resulting from a particular risky behavior would impose significant barriers to one's ability to pursue one's fair share of society's normal opportunity range, then equality of opportunity would have to prohibit this assignment of liability.[111]

This criterion for normality will by no means apply to all risky behaviors,[112] but there are a variety of health risks that would likely fall into this category. Working long hours at a stressful job can pose significant health risks, but the ability of anyone to do so is essential to fair competition. Another example is having children, which is a voluntary activity with significant health risks. The risks associated with childbirth ought to be considered normal, since the ability to have children is essential to the life plans of many of us, and is therefore undeniably part of the normal opportunity range for our society. This criterion for normality will also include many of the tiny risks associated with everyday life. We run a gamut of risks just by stepping out of our doors each morning,[113]

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[111] Whether a given risk is considered crucial to equality of opportunity will depend upon the normal opportunity range for that society. As I discussed in chapter 2, a society's normal opportunity range is relative to key features of that society: its stage of historical, economic, and technological development. While a risk such as driving might be considered essential to equality of opportunity in modern, industrial societies, it would be irrelevant in a society with no cars.

[112] Smoking, for example, is not likely to be crucial to equality of opportunity.

[113] We might be swept away by a tornado, or run into someone on the street with a highly communicable disease.

but these risks are considered normal, since we must run them simply in virtue of pursuing our fair share of our society's normal opportunity range.[114]

We may also wish to consider a risk normal for pragmatic reasons. There may be some risky behaviors that are not crucial to equality of opportunity, but many of us engage in, and want to be able to continue engage in, without being held liable for the costs of our care should we develop any health problems as a result of our gamble.[115] Put another way, we might want to consider a risk normal if we believe that the benefits the majority of us gain from being able engage in it without being held liable for any resulting health care costs are sufficient to outweigh the financial costs to society of the resulting health care needs.

On pragmatic grounds, risks should be considered normal when the benefits of the risky behavior outweigh their costs to society. Conversely, risks should be considered excessive when the financial costs of a risk exceed the benefits members of society can be expected to receive from the risky activity. Unfortunately, there is no well-established method for determining whether a risk should be thought of as normal or excessive in this sense. Currently, we are guided mostly by our intuitions, and general social attitudes. I will now offer some thoughts on how we might go about determining whether a risk should be thought of as normal for pragmatic reasons.

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[114] Earlier, I pointed out that equality of opportunity would not require an auto-induced health condition to be treated with public funds simply because of its effect on the risk taker's post-gamble opportunity range. Here the issue is importantly different. In this case, liability would not be assigned for certain kinds of risky behaviors, because to do so might unjustly restrict someone's pre-gamble opportunity range.

[115] Exactly which behaviors will be evaluated for their pragmatic value is somewhat dependent on which risks will be considered crucial to equality of opportunity. While driving a car may be considered essential to achieving one's portion of the normal opportunity range, it might not be considered crucial that one need to be able to ride a motorcycle, an activity that is very similar to driving a car, but which involves much higher risk of major injury. Motorcycling could therefore fall under those risks that *might* be evaluated as normal, either because of its effect on equality of opportunity or for pragmatic reasons.

Unlike the other cases of acceptable risk, assessing whether or not a risk is normal in the pragmatic sense is not entirely straightforward. As I have described above, we can establish whether or not a risk was voluntary by examining whether a risk was taken deliberately, and whether a risk taker had any reasonable alternatives. Also, we may determine a risk to be normal if it is crucial to equality of opportunity. These assessments are primarily matters of fact,[116] and they can be evaluated empirically with relative ease. The issue of what sorts of risks ought to be understood as normal for pragmatic reasons, on the other hand, is primarily a matter of value.

The first issue to consider in determining whether a risk is normal on pragmatic grounds is the matter of the benefits people expect to receive from risky behavior. The benefits we expect to receive can be of almost any kind.[117] In the case of riding a motorcycle rather than driving a care, people may expect the benefits of convenience and the level of personal freedom that a motor vehicle can offer, along with the added benefit of style and excitement. Another benefit one might expect from an activity is the ability to participate fully in a culture or subculture, in this case, the subculture of a motorcycle club. Participation in one's culture or subculture may in fact be an important benefit people expect to receive from a large number of risks. The consumption of fatty foods is a component of a number of cultures, as is the consumption of large quantities of alcohol.

The important thing to note about benefits is that the degree to which they are considered desirable is a product of individual and cultural values. For example, the

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[116] I say *primarily* a matter of fact, since in my opinion, facts and values can rarely, if ever, be completely separated. Facts tend to shape values, while at the same time, values can often shape facts. An explanation of the intertwined nature of facts and values can be found in Fischhoff 1981, 43-46.

[117] Of course, some of us could enjoy many of the benefits of risky behaviors even if we were held liable for the costs of any resulting treatments, but with some risky behaviors, such motorcycling, the costs of being held liable for one's health care costs would be prohibitive for many of us. The key advantage to having the costs of a risky behavior covered by the right to health care is that it would allow the opportunity for nearly universal participation in the given risky behavior.

value placed on alcohol or rich foods varies greatly from culture to culture. This relativity, inherent in the concept of benefits, poses potential problems in trying to calculate acceptable risk cross-culturally. In so far as they can be calculated, the overall benefits of a given risky behavior will be based on two factors: the value that people within a society place on a given behavior, and the degree of participation in the behavior (the number of people expected to enjoy the benefits).

The costs to society against which the benefits of a risky activity will be measured are financial. These costs constitute the amount of money that society would have to spend to provide care to risk takers for their self-induced health problems. The costs of a risky behavior will be primarily determined by three factors. The first is the actual level of risk an individual runs by engaging in a particular behavior. That is, the probability that an individual will develop a health problem as a result of his gamble. The second factor that will determine the actual costs to society is the level of participation in a given risky behavior. That is, the number of people in a society who engage in the risky behavior. The third factor is the amount of health care resources required for treatment for the appropriate health condition. Taken together, these three factors will determine the financial costs of treating those who take a particular risk with their health. It must be noted that while the actual financial costs of treatment can be determined objectively, the degree to which the costs are either prohibitive or acceptable will be relative to a societies' level of wealth. A very wealthy society is more likely to be able to bear the financial costs of risk taking than a very poor society.

On the surface, the issue of determining what sorts of risks ought to be considered normal for pragmatic reasons might appear to be a simple matter of

cost/benefit analysis. Unfortunately, this sort of analysis is problematic, because cost-benefit analysis can only adequately account for consequences that have dollar values.[118] While the costs of a given risky behavior are primarily financial, the benefits of the same risky activity are in most cases noneconomic. While a simple cost-benefit analysis will not be sufficient to determine which risks should be thought of as normal, and which as excessive, there are other methods available. Some of the methods of risk analysis for public policy makers discussed by Fischhoff et.al.[119] could likely be modified to provide some guidance in deliberations on the normality of risks. The most successful of these would likely be the decision analysis method, since it explicitly accommodates subjective value judgments, which will be essential in adequately accounting for the value placed on different benefits, both intra and inter-culturally.[120]

While a formal method of risk analysis, such as the decision analysis method, may prove effective in determining the normality of a risk, there is another method that might be employed. The value placed on the benefits of a given risk, and the degree of participation in that risk, will both be determined by the values and behavior of the citizens of a given society. Likewise, the financial costs of publicly funding treatments for any health problems resulting from the risk will ultimately fall upon the citizens of

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[118] Fischhoff 1981, 106-12

[119] Fischhoff 1981

[120] Briefly, the decision analysis method of risk assessment is based upon formally defined principles of rationality. It attempts to evaluate and compare the advantages and disadvantages of proposed actions by evaluating expected aggregate utility of each option in a given decision problem. The decision problem is defined by listing the set of alternative courses of action, and the set of all possible consequences of each of these actions. The relationship between each alternative and its possible consequences, as well as the probability of those consequences, must be described. All consequences are then evaluated using a common unit, specifically, subjective value judgments of utility. In principle, these value judgments can accommodate everything from soft considerations such as esthetics, to hard considerations such as monetary cost. This process also includes subjective attitudes towards the desirability of various levels of risk. The components of the analysis are then integrated to produce a bottom-line number evaluating each alternative, which will express the option's expected utility. This expected utility is the sum of the utilities of each possible outcome, weighed against their respective probabilities of occurring. Fischhoff 1981, 106

that same society. It might be reasonable then, to employ a democratic mechanism for establishing whether the citizenry wishes to consider a given risk either normal or excessive. Obviously, any such mechanism would require a great deal of expert participation in order to make clear to the citizenry the real costs of any given risk. It will also require a great deal of deliberation and debate, as citizens sort out how much value they actually place on the benefits of various risky activities.[121] Such a mechanism would likely prove unwieldy, but I think it might best answer the question of which risks a society believes are normal, and which it believes ought to be treated as excessive.

Without actually implementing such a mechanism, it is impossible to know with certainty which sorts of risks would be considered normal. I will, however, speculate briefly about how Canadian citizens might respond through such a mechanism to the risks posed by smoking cigarettes. The benefits of smoking would likely be determined to be quite small. Smoking provides a brief and modest pleasurable experience for the smoker. The level of participation is significant, but it does not include the majority of Canadians.[122] The overall costs of treating smoking related illnesses is quite high, due to the very high level of health risk associated with smoking, as well as the high price of treatment. Given the shoddy benefits, the low level of participation, and the high costs for society, I think it likely that smoking would be considered an excessive risk, and that at a result, the responsibility sensitivity of the right to health care ought to be activated.

It should now be clear that while the right to health care is, in principle, responsibility sensitive, actually determining whether or not that sensitivity should be

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[121] This may be the very sort of task to which models of deliberative democracy would be most effective at resolving.

[122] In 2001, only 22% of the population over the age of 15 were smokers. Source: Canadian Council for Tobacco Control Website.

activated will be a complicated procedure. We must be able to confirm that the risk was voluntary, and that the risk was excessive. If we wish to hold people liable for the costs of their care, work will need to be done to establish exactly which risky behaviors are crucial to equality of opportunity, and which risks, if any, ought to be considered normal for pragmatic reasons. For the moment, however, I think it is safe to assume that risks posed by smoking will prove, for the majority of smokers,[123] to be both voluntary and excessive. For this reason, we are likely justified in holding most smokers liable for the costs of their care.

In this chapter, I began by explaining that the right to health care is responsibility sensitive, because its purpose is to remove arbitrary barriers to opportunity, in order to insure that, as much as possible, our lives are governed by the consequences of our choices. I went on to argue that there are conditions under which the responsibility sensitivity of the right ought not to be activated. The first such case is a situation in which the gamble taken by an individual was not fully voluntary, either because the gamble was not deliberate, or because the risk taker had no alternative but to gamble. I then went on to explain that there are some risks which are considered normal, and are therefore thought of as acceptable. A risk may be thought of as normal if it is either crucial to equality of opportunity, or if it is desirable on pragmatic grounds.

[123] As I explained earlier, an exception would be made for those smokers who began before the risks were known, and therefore did not deliberately gamble with their health.

Conclusion

Cost Recovery

One major issue that I have not addressed in this thesis is how those patients who have taken unacceptable risks with their health should be held liable for the costs of their care. My reason for postponing a full discussion of this is that I believe the necessary research on cost recovery is not best done by a philosopher, but rather by someone with experience in, and knowledge of, public policy and governance. Nevertheless, I do wish to offer some preliminary thoughts on the potential advantages and disadvantages of some of the methods of cost recovery that could be implemented. The three methods I will discuss here are all aimed at recovering costs within a public health care system such as Canada's.

The first, and most straightforward, method of cost recovery would be to implement user-fees within the public health care system for those suffering from auto-induced health problems. Such a system would have two primary advantages. The first is simplicity. It would not require the implementation of new taxes, or the establishment of a complex insurance market for risk-takers. Indeed, the new bureaucracy associated with the implementation of such a system might be fairly modest.[124] The second major advantage of such a system is that it would be able to cover nearly all health problems resulting from risky behavior. Whether the patient suffers from smoking related cancer,

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[124] The most important new bureaucracy required under such a plan would be a system for determining whether a patient's health problem was induced through an unacceptable risk. Due to the many factors I discussed in the previous chapter, this would not be an entirely straightforward process. Also, the simplicity of such a system relies on the hope there would not be substantial litigation launched by risk takers hoping to avoid the costs of their treatments. Further, such a system would likely be subject to substantial fraud, as risk takers would have little incentive to be honest about their behavior when seeking treatment. As a result, the financial and social costs of such a system would likely include the costs of fraud and/or policing.

or a backcountry skiing accident, this system would be able to recover the costs of treatment, since it bills at the time of health care delivery.

The potential disadvantage of this method of cost recovery is that it would present barriers to health care for those of lower income; barriers that might lead to consequences that could be interpreted as immoral. Treatments for diseases such as lung cancer are extremely expensive; far beyond the ability to pay of those of lower income. Under a system of user-fees, it seems very likely that only those risk takers who are better off financially will be able to afford treatment for their self-induced health problems. Those who are too poor to pay for their treatments would be left to suffer from their auto-induced conditions. To some, this may seem to be perfectly reasonable. It might be said that those risk takers who were better off made gambles they could afford to lose, while those who were poor acted foolishly by gambling beyond their means. Leaving people in pain and suffering, however, would likely strike many of us as morally problematic, especially if it is within our power to prevent this suffering. We might think that those who gambled beyond their means were foolish to do so, but this will not necessarily reduce our concern over the fact that they would be left to suffer under such a system of cost recovery.

This method of cost recovery would also likely face a significant political hurdle. A large portion of the Canadian public is currently very concerned about the future of the public health care system. A method of cost recovery that would restrict the ability of those of lower income to access services available to the wealthy may be perceived in a way that would generate a great deal of political opposition among Canadians. That the restrictions would apply only to health problems the patients brought upon themselves

might not matter to a portion of the public. It may be that a system of user fees would simply bear too much superficial resemblance to a 'two tier' system for a portion of the public to tolerate.[125] If this were so, it might be easier, politically, to simply use a method of cost recovery, such as the "risk tax" method, that involves as few changes to the health care system as possible.

The second method of cost recovery that could be implemented is based on the current practices of private insurance companies. This method would require those who take risks with their health to pay increased insurance premiums in order to cover the costs of any treatments they might need as a result of their risky behaviors.[126] Under British Columbia's current public system, for example, citizens pay Medical Service Plan premiums, which could be increased for those who take unacceptable risks with their health. Such a system would require honest disclosure from patients, so that any unacceptable risks could be accounted for in calculating individual premiums.

The advantage of this system is that like the user-fees system, it would be able cover the majority of risky behaviors. Also, it could potentially avoid the sorts of moral concerns faced by the user-fees system, since an increased insurance premium poses a much smaller barrier to care than the full cost of a serious medical intervention.

A potential concern this method might generate is a worry about the degree to which it would require the government to pry into the private lives of its populace. The

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[125] This superficial resemblance might be exacerbated by media coverage, which tends towards sensationalistic coverage of most issues.

[126] Currently, private insurers charge additional premiums not only to those individuals who voluntarily increase their probability of developing health problems, but also those individuals whose probabilities of developing health risks are above average due to non-voluntary factors, such as genetic predisposition. I should note that under the right to health care I have described, this latter practice would be unacceptable, since one's genetic makeup is not something over which one has any control. Liability for health risks is assigned when one has voluntarily assumed an excessive risk, not when one's probability of developing health problems is due to a non-voluntary factor.

process of determining which risky behaviors each citizen is engaged in, and which of those risks ought to be considered unacceptable, would likely be highly invasive. These measures might be thought to exceed the desired level of government involvement in the lives of its citizens.[127] A proponent of this method of cost recovery would probably need to address this concern, either by demonstrating why such measures would not be unacceptably intrusive, or making the case that such intrusion is truly necessary.

The third method of cost recovery I will consider is the application of a "risk tax" onto those products and services determined to pose unacceptably high levels of risk to users. Unlike current "sin taxes" on products such as alcohol and cigarettes, the revenue generated by these taxes would be directly siphoned into research and treatment of the health problems caused by the appropriate products. Taxes would need to be calculated separately for each product and service so that each individual tax would accurately reflect the costs or treatment for any resulting health problems. There are several potential advantages to such a strategy. First, this method would not require any government intrusion into the lives of risk takers, since there would be no need for post-gamble cost recovery, and therefore no need to identify risk takers from the general citizenry. Another potential advantage is that users of these risky products would be paying for the full costs of their risks, and they would be doing it pre-gamble. The costs of the extra insurance premiums required to cover the expense of any health problems they may develop are included in the price of the product. People can therefore not

[127] This sort of worry might also be extended to private insurance companies, who currently obtain information regarding the risky lifestyles of those applying for insurance. It may be that many of us wish to retain as high a degree of privacy in our lives as possible. This desire for privacy does not undermine the importance of cost recovery, but rather it might simply motivate us to prefer a system of cost recovery that does not involve intrusion into our private lives.

gamble beyond their means, since their means will determine the degree to which they can gamble.

Another advantage of this method is that in most cases, those taking the greatest risks would wind up paying the highest taxes. A smoker who smokes two packs of cigarettes a day is likely running a much higher risk than a casual smoker who only has a cigarette every other day. Under this system, the heavy smoker would be paying much higher "risk taxes" than the casual smoker, since the amount of tax paid will be a result of how much of a product or service one purchases. This seems appropriate in most cases, though the case of alcohol may prove a notable exception. A great deal of research has suggested that consuming a small amount of alcohol on a regular basis, such as a glass of wine a day, can have beneficial effects on one's health. It might be seen as problematic to charge a "risk tax" to those who drink a glass of wine a day, since they are not risking their health by doing so, but are instead improving it. Of course, the actual "risk tax" these moderate drinkers would be paying might be small enough that it is considered more or less negligible, especially next to the already substantial "sin taxes" that currently levied on alcohol.

The primary disadvantage of this method of cost recovery is that it will only be applicable to those risky products and services that fall within the legitimate public market. There are a range of legitimate risky activities that fall outside of the marketplace, and as a result these activities will not be able to be taxed.[128] Similarly, there is a range of risky activities that are market based, but are illegal, and as such they fall outside of the legitimate market. Most notable among these is intravenous drug use. On top of the health problems created by the injected narcotics, the sharing of needles by

[128] Unprotected consensual sex is one example of this sort of activity.

users has resulted in the spread of diseases such as HIV and Hepatitis C. While intravenous drugs such as heroin and morphine are bought and sold on a daily basis, the market upon which they are traded is not currently within our ability to regulate, let alone tax. As a result, the "risk tax" method of cost recovery might not be able to account for all of the risky behaviors covered by the other methods.

Obviously, the issue of cost recovery is an important one, and I have only been able to touch on briefly it here. There are other methods of cost recovery that I have not considered; including systems that attempt to blend some of the methods I described above. Hopefully, however, my comments provide some sense of the complexities, both conceptual and practical, that will face attempts to implement a system of cost recovery. I believe that more research is needed in this area, preferably by someone well versed in issues of policy and governance.

Final Remarks

In the introduction, I identified two central questions that I would address in this thesis. The first was whether it would be acceptable to withhold treatment from risk takings patients altogether. The second was whether the financial burden of treatment could be placed upon those whose risky behavior caused their health problems. In order to answer these questions, I began by examining Gerald Dworkin's attempt to deal with the issue of personal responsibility for self-induced health problems. I argued that his approach alone is insufficient to constitute a complete account of the appropriate response to risk taking patients, because of his failure to conceive of risks as gambles, to distinguish between option luck and brute luck, and to frame his question in terms of the right to health care.

In response to the inadequacies of Dworkin's approach, I framed my discussion around the right to health care, and the degree to which it is responsibility sensitive. I argued that Norman Daniels' theory of the right to health care, which is based upon a principle of equality of fair opportunity, is the best account of the right available. I then argued that the right to health care ought to be understood as responsibility sensitive, since the purpose of the principle of equality of opportunity is to insure that our lives are governed, as much as possible, by the consequences of our choices, rather than arbitrary circumstances. I went on to explain that while the right to health care is responsibility sensitive, not all risks taken by individuals are sufficient to activate the responsibility sensitivity of the right. I argued that for a risk to engage the responsibility sensitivity of the right, it must be voluntary, and that the risks must be considered to be excessive.

Having finished my discussion of the right to health care and the degree to which it is responsibility sensitive, the answer to my first question is that it is not justifiable to withhold treatment from risk taking patients altogether, even when it can be clearly demonstrated that those patients caused their own health conditions through their risky behavior. The right to health care as I have developed it is concerned with who ought to bear the costs of treating health problems. I have argued that if one's health problem was the result of option luck (and the risk was excessive), then it falls outside of the right to health care. This means that the costs of treating self-induced health problems should not be paid for by a national health plan. It does not in any way imply that there is reason to withhold treatment from risk takers altogether. This leads naturally to the answer to my second question, which is that the costs of treating self-induced health problems should be born by those patients who have gambled with their health and lost, at least when

those patients have gambled voluntarily, and the risks they have taken are considered excessive.

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