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Discrimination Based on Personal Responsibility: Luck Egalitarianism and Healthcare Priority Setting

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Abstract

Luck egalitarianism is a responsibility-sensitive theory of distributive justice. Its application to health and healthcare is controversial. This article addresses a novel critique of luck egalitarianism, namely, that it wrongfully discriminates against those responsible for their health disadvantage when allocating scarce healthcare resources. The philosophical literature about discrimination offers two primary reasons for what makes discrimination wrong (when it is): harm and disrespect. These two approaches are employed to analyze whether luck egalitarian healthcare prioritization should be considered wrongful discrimination. Regarding harm, it is very plausible to consider the policies harmful but much less reasonable to consider those responsible for their health disadvantages a socially salient group. Drawing on the disrespect literature, where social salience is typically not required for something to be discrimination, the policies are a form of discrimination. They are, however, not disrespectful. The upshot of this first assessment of the discrimination objection to luck egalitarianism in health is, thus, that it fails.

Keywords: discrimination; personal responsibility; luck egalitarianism; life-style discrimination

Introduction

Non-communicable diseases are an increasing part of the global burden of disease. Half the significant causes of death are non-communicable diseases,¹ which comprise a considerable share of healthcare spending.² This has intensified discussions about personal responsibility in health.³ Around the world, personal responsibility is used, or proposed, as a criterion to ration access to treatment. In the Netherlands, personal responsibility is one of the criteria for deciding what should be part of public healthcare.⁴ In Germany, the degree of out-of-pocket payment for dental care increases for those who fail to attend checkups with the required frequency.⁵ In the United Kingdom, Clinical Commissioning Groups within the National Health Service have proposed restricting elective surgery for smokers and the obese.⁶ Others suggest that people who need a new liver because of alcohol consumption should be considered ineligible for transplantation⁷ or that personal responsibility might be a reason to differentiate between the unvaccinated and the vaccinated.⁸ Substantial parts of the public are willing to employ personal responsibility as a rationing criterion.⁹ This view is also found among practitioners,¹⁰ albeit they perhaps use the idea of personal responsibility in a broader sense.¹¹

In light of this prevalence of interest in health and personal responsibility, we have seen several attempts to apply luck egalitarianism, a responsibility-sensitive theory of justice, to questions of health and healthcare.¹² Luck egalitarianism considers distributions just, if and only if they reflect people's relative exercise of responsibility.¹³

Luck egalitarianism is a controversial theory, especially in the context of health.¹⁴ It has been claimed to be overly harsh toward the imprudent,¹⁵ require people to reveal intimate histories in assessing

responsibility,¹⁶ unfairly affect the worst off,¹⁷ allow people to gradually descend into a very bad state of affairs,¹⁸ and fail to protect capacity for future choices.¹⁹

There is a rich literature addressing the various merits of these objections. This article examines a different, yet overlooked, critique against luck egalitarianism in health, specifically that responsibility-sensitive policies are instances of (wrongful) discrimination against those who are responsible for their bad health.²⁰ Elizabeth Anderson first suggested the contours of such a critique in her seminal critique of luck egalitarianism.²¹ Although her critique covers different areas of life, it submits that luck egalitarianism requires wrongful discrimination because it implies that those responsible for their bad situations should bear the associated costs. This thought seems especially pertinent in health. In addition to this theoretical relevance, this question has real-world relevance. Concerns of what is sometimes termed *lifestyle discrimination* come to the fore in the public debate.²² Joar Björk notes how the documents guiding priority setting in Sweden state “that level of self-inducement and differences in lifestyle should, as a principle, not lead to negative discrimination.”²³ Proposals to increase the role of personal responsibility in the NHS in the United Kingdom were resisted with claims about their discriminatory nature.²⁴

It is a significant omission that the burgeoning literature on luck egalitarianism in health has failed to develop and address this critique. This article is the first attempt to rectify this issue. Specifically, it asks whether policies that give lower priority to those deemed responsible for their health disadvantages should be considered wrongful discrimination. Here, lower priority means that the policy provides those deemed responsible for their bad health lower priority than others when determining access to free healthcare. Thus, lower priority need not imply that care is denied to anyone but that a person must wait longer for treatment or pay part of the associated costs. Such policies are assessed by drawing on two strands of thought in the philosophical literature about discrimination. One relates the wrongness of discrimination to harm, whereas the other focuses on disrespect.

Before conducting this discussion, it is important to be clear about the article’s limitations and explicitly lay out the assumptions utilized in the discussion. As this is the first attempt to discuss thoroughly a discrimination objection to luck egalitarianism in health, there are limits to what the article can cover. The responsibility-sensitive policies discussed are assessed under somewhat idealistic circumstances. The purpose of doing so is to ensure that any wrongfulness identified stems from the policies, not from a particular (problematic) implementation. The first assumption is that the policies are implemented throughout the healthcare system, not just for a subset of diseases and behaviors. They thus apply to everyone responsible for their bad health. This assumption sets aside concerns about responsibility-sensitive policies being implemented only for behaviors more prevalent among the less well-off.²⁵

Another assumption is that some are responsible for their health disadvantages. Luck egalitarians usually do not commit themselves to a specific theory of what it means for people to be responsible.²⁶ In a similar vein, this contribution will remain neutral in this regard. It is, however, assumed, for the sake of discussion, that there are people who are responsible for their health disadvantage and people who are not. This is taken to imply that people are relatively equal or have sufficiently equal opportunities when making health-related choices. Furthermore, to set aside concerns regarding intrusion, it is assumed that distinguishing these groups is relatively easy.

The sum of these assumptions is that we can clarify responsibility and that doing so is worthwhile because there are both individuals who are and individuals who are not responsible. The assumptions are made for the discussion to be more manageable, but we should also be interested in what happens when they are relaxed. The conclusion further reflects on how relaxing the assumptions might affect the verdicts reached in the discussion.

Discrimination and Harm

There is a family of views that locate the wrongness of discrimination in terms of how it harms individuals or groups, typically the victims of discrimination. Katharina Berndt Rasmussen notes that

the legal sphere has increasingly emphasized the harmful effects of discrimination (as opposed to malice or intent).²⁷

On a particularly influential account of the harm-based wrongness of discrimination proposed by Lippert-Rasmussen, the distinct focus is on discriminatory policies that harm socially salient groups.²⁸ This approach thus leads us to ask whether the policies in question cause harm and whether those affected by this are members of a socially salient group.

Consider first whether the policies are harmful. There is, of course, a very rich philosophical literature on the nature of harm. But this article need not dwell on the various details of this. The reason is that if we ask whether different understandings of harm would deem that the responsibility-sensitive policies harm those responsible for their health disadvantage, the verdict is quite clear. These policies do harm those affected by them. This is true irrespective of whether harm is understood as a comparative or non-comparative notion.²⁹ And, among comparative notions, it is true across various suggestions for baselines to use in this comparison.³⁰ That is, they are worse off irrespective of whether the baseline for comparison is a situation where the discriminatory act had not happened, how they were before the policy's introduction,³¹ a situation with no discrimination, or one where everyone had acted morally permissible from the time of the discriminatory act.³² A similar verdict is reached when we look at the broader philosophical literature on harm. If we use understandings of harm based on counterfactual,³³ historical,³⁴ and occupied states,³⁵ these policies are instances of harm. Thus, responsibility-sensitive policies harm people responsible for their health disadvantages.

The fact that the policies are considered harmful is, as already mentioned, insufficient to show that they constitute instances of wrongful discrimination. If that were the case, any instance of healthcare priority setting would be wrongful discrimination. The question is whether those harmed by luck egalitarian policies are members of a socially salient group. Kasper Lippert-Rasmussen defines discrimination in the generic sense, as follows:

An agent, X, discriminates against someone, Y, in relation to another, Z, by Φ -ing (e.g., hiring Z rather than Y) if and only if:

- 1) There is a property, P, such that Y has P or X believes that Y has P, and Z does not have P or X believes that Z does not have P.
- 2) X treats Y worse than he treats or would treat Z by Φ -ing.
- 3) It is because (X believes that) Y has P and (X believes that) Z does not have P that X treats Y worse than Z by Φ -ing.³⁶

When we discuss group discrimination, it is added that "P is the property of being a member of a certain salient group (to which Z does not belong)."³⁷ Thus, group-based discrimination is when some are treated worse than others based on perceived or actual membership of a socially salient group. The emphasis on membership of socially salient groups might be said to mirror the legislative practice, as protected categories such as gender and race are socially salient. Are the described policies direct group discrimination on Lippert-Rasmussen's account?

When we consider a person who is responsible for his bad health (Y) and one who is not (Z), there is indeed a P (responsibility for health) such that Y has P and Z does not have P, and this is precisely the reason why the healthcare system (X) treats Y worse than Z. The important question is whether P is the property of being a member of a salient group. That is, whether those responsible for their own health disadvantage is a socially salient group. According to Lippert-Rasmussen, a "group is socially salient if perceived membership of it is important to the structure of social interactions across a wide range of social contexts."³⁸ The social salience of a group is a matter of degree, and group membership may be important in different ways. It may "be anything from slightly important to wholly dominant in the structure of social interactions, and it may be important in more or fewer social contexts."³⁹ With this in mind, does the policy disadvantage someone based on (actual or perceived) membership of a socially salient group?

A first attempt at showing this to be the case would be to point out that some in this group are members of the socially salient group of smokers. Even if we assume the truth of the claim that smokers

are a socially salient group, this attempt at describing those adversely affected by the policy as a socially salient group does not work. There are several reasons for this. First, not all risky health behaviors are as visible and defining as smoking, so even if successful for smokers, it would fail to capture many health behaviors, such as excessive exercise. Second, membership (perceived or actual) of the group of smokers is insufficient for receiving lower priority. Only those smokers who suffer bad health effects and are responsible for their behavior will receive lower priority. Thus, even if all smokers would (in their daily interactions) be perceived to be part of the group responsible for their own bad health, this mistake would not be replicated by the healthcare system. Here, smokers would be treated differently based on their exercise of responsibility. The healthcare system, therefore, does not treat smokers differently because they are smokers. They do so only to the extent that they are responsible for smoking that this exercise of responsibility has caused their health disadvantage. Thus, not all smokers will be discriminated against, and nobody will be discriminated against because they are members of the socially salient group of smokers. So, even if smokers are a social significant group, this does not make it true that the policies in question discriminate against anybody because of their membership of a social salient group.

So, let us again consider whether the group responsible for their bad health constitutes a socially salient group. It is hard to see that “perceived membership of it is important to the structure of social interactions across a wide range of social contexts.”⁴⁰ Note, however, that the inclusion of ‘perceived’ means that it is not enough to reject the social salience of being responsible for one’s health disadvantage, that people would often not know whether a person is a group member. It would be sufficient if perceived membership were important in many interactions. However, it is hard to see that perceived membership would structure interactions such as friendships and career opportunities. Therefore, it is hard to classify the described policies as discrimination because, although those who are indeed made worse off by the policies are done so for a characteristic that does indeed make them part of a group, this is not a socially salient group.

However, in his discussion of social salience, Lippert-Rasmussen allows that a policy targeting a specific group may make group membership salient. Even if the group responsible for their bad health is not initially a socially salient group, the policy in question could make it one. Clearly, under the described policy, there is one sphere of life—the encounter with the healthcare system—where actual group membership is seemingly very important. Although such an argument for the social salience of group membership initially seems more promising than those just discussed, there are good reasons to find it unpersuasive. The problem with the argument is that responsibility for health disadvantage relates to a specific illness or condition. It is not an all-or-nothing judgment that affects every encounter with the healthcare system. As it were, you can be responsible for the bad state of your dental health but not for the injuries sustained in a car crash. This nature of the judgment of responsibility strongly suggests that it is implausible that introducing a responsibility-sensitive priority scheme will make group membership of the group of people responsible for some bad health state salient. It also considerably speaks against the very notion that the group is socially salient when membership is not an either–or thing but rather contextual. On consideration, at various stages and for different conditions, we would sometimes belong to the group and sometimes not—something that strongly suggests that the group is not socially salient and that the policy will not make it so.

The above suggests that there is some feature, responsibility for health disadvantage, which makes it so that some are treated worse than others under a responsibility-sensitive policy. This policy harms those disadvantaged by it. Despite this, such a policy should not be considered an instance of group-based discrimination by Lippert-Rasmussen’s definition. This is because the group of people responsible for their health disadvantage is not socially salient.

Discrimination and Disrespect

Consider, then, disrespect-based accounts of the wrongness of discrimination. These amount to the claim that discrimination is wrong when it is wrong because it shows disrespect. Notably, several theories that locate the wrongness of discrimination in disrespect employ an understanding of what discrimination is, which does not have a criterion of social salience. Several writers have questioned the relevance

of the social salience criteria. Although these authors acknowledge that many of the worst forms of discrimination are against socially salient groups, they argue that this does not mean that disadvantageous treatment of other groups should not be considered discrimination.⁴¹ Focusing on socially salient groups would then seem to have historical roots rather than be a conceptual necessity.⁴² For such reasons, Eidelson (include first name when the author introduced in text) has proposed a definition where X (directly) discriminates against Y in dimension W on the basis of P if and only if:

- 1) “X treats Y less favorably in respect of W than X treats some actual or counterfactual other, Z, in respect of W” (*Differential Treatment Condition*).⁴³
- 2) “A difference in how X regards Y P-wise and how X regards or would regard Z P-wise figures in the explanation of this differential treatment” (*Explanatory Condition*).⁴⁴

Eidelson’s definition most clearly diverges from Lippert-Rasmussen’s because it does not include a clause of social salience.⁴⁵ Eidelson clarifies that the explanatory condition is not about X’s rationale or the explanation X would give for their actions but rather about whether how Y is regarded contributing to explaining the action. Importantly, regarded here means considered but not in a derogatory sense. What matters is whether how a person is regarded with respect to some feature explains the differential treatment.⁴⁶

Would the policies under consideration be considered discrimination by Eidelson’s definition? It seems clear that the policy fulfills the differential treatment condition. The healthcare system treats the imprudent less favorably with respect to access to healthcare than the healthcare system treats some actual or counterfactual other Z when that other is a person who has bad health because of matters unrelated to exercises of responsibility. Does the case at hand fulfill the explanatory condition? According to this condition, the difference in how the persons are treated must bear on how the persons treated in this way are regarded. What does regarded mean here? Here, this would be responsible for bad health. Based on this, it seems reasonable to consider the policies under examination as discrimination when using Eidelson’s definition.

But, although perhaps instances of discrimination, this is in a non-moralized sense. We can turn to whether it is wrongful discrimination starting with Erin Beeghly’s very useful overview of the disrespect literature. Beeghly submits that there are three versions of the disrespect account.⁴⁷ Specifically, these accounts relate to mental states,⁴⁸ objective meaning or expressive accounts,⁴⁹ and deliberative theory.⁵⁰ With the prominence of these accounts, it becomes interesting to consider whether the policies under consideration are wrongful because they disrespect people in the stated manner.

Consider, first, the mental state accounts. Mental state accounts argue that when discrimination is wrong, it is because it reflects a certain morally objectionable mental state of the discriminator. These are the cases where the person conducting the discrimination thinks badly about the person or the group discriminated against (i.e., holds some problematic belief about them).⁵¹ The person not hiring a black person because of a distaste for this group is an example of such disrespectful discrimination. Under the circumstances discussed here, where the group of people who are responsible for their bad health is broad and includes people who have behaved irresponsibly in quite different ways, it is difficult to envision that the mental state account of disrespect is going to take us far in terms of capturing the wrongness of the situation. After all, we might have hikers, smokers, and road cyclists among the affected, and they have little in common.

You can plausibly will that people should pay (a part of) the cost of their own behavior or be treated later than others without thinking badly about them as persons (or at all). However, if the responsibility-sensitive policies were incompletely implemented so they would target only specific behaviors or diseases, then it could be the case that the mental state account would be more relevant because such targeted policies could involve problematic mental states. It should also be noted that a responsibility-sensitive policy *could reflect such* bad mental states (reflecting a sentiment that the irresponsible deserve to suffer). What has been argued here is that it need not.

Consider, then, the objective meaning accounts. These accounts locate the wrongness of discrimination in its objective meaning. This contrasts with the disrespect account just discussed, as on the

objective meaning account of disrespect discrimination, nobody needs to think badly about the persons or group discriminated against. Instead, the worry is about the meaning this policy expresses. Meaning, here, is usually taken to be objective, and whether a policy has a specific meaning can only be understood by analyzing its particular context.⁵² According to Deborah Hellman, a leading proponent of such an account, the meaning of a discriminatory policy is problematic when it is demeaning. Specifically, this relates to instances where the policy expresses “that a person or a group is of lower status,”⁵³ and the “actor or institution expressing this meaning must have sufficient social power for this expression to have force.”⁵⁴

Does this work as an account of the wrongness of responsibility-sensitive healthcare policies? It has much more going for it than the mental state-based disrespect account. This is the case because we do not have to evoke the (in this context) questionable idea of mental states. Policies can come to express a problematic meaning, even if those who enact them do not have a problematic mental state regarding those who are discriminated against.

Is it possible to suggest that the responsibility-sensitive policies under discussion fulfill Hellman’s criteria? We can first ask whether the power condition is fulfilled. Should politicians passing responsibility-sensitive legislation and healthcare systems implementing be considered to have sufficient social power to express a specific meaning? To see that this is plausible, we only need to imagine policies denying treatment to already oppressed and disadvantaged groups (i.e., the insufficient health provided to black citizens during South African apartheid). Health is a good of such importance that it is distributed and can potentially carry a significant social meaning.

However, that the responsibility-sensitive policies we are discussing here check all the right boxes on the power dimension is only halfway to show that the policies are demeaning. The next question is whether they express lower status. At the same time, it has already been mentioned as an advantage of this approach that we do not have to say that there are any problematic mental states present, the reply to the question of lower status shares many similarities with that given in the preceding section. If properly implemented and applied across a wide range of behaviors, there is no need to consider it to express that those who are asked to wait longer or pay (a share of) the cost of treatment are worth less than others. To see why this is the case, consider that in any healthcare system with scarce resources, somebody will have to wait, and only some things are available for free. Distributing goods according to whether people are responsible for their health needs can be plausibly considered a fair way of (partially) addressing the scarcity—and it is at least not straightforwardly demeaning, just as saying that a specific treatment is too expensive is also not in itself demeaning.

However, this reply underscores that this is one of the areas where it matters whether the responsibility-sensitive policy is properly and consistently implemented. If not, and there are considerable inequalities in health, then people from bad socioeconomic circumstances can feel hard done by. At least if there is a significant social inequality in who is deemed responsible for their bad health, those from lower socioeconomic positions can feel that the policy is targeting them and perhaps experience this as another instance where the state did little for their communities and those residing there.

There is a possible rejoinder to this kind of reasoning, which is that even if we ensure that we perfectly detect whether people are responsible or not, it could still be the case that most people who are, correctly deemed to be responsible for their bad health is from lower socioeconomic groups. Again, the concern of disrespect presents itself. This is a concern if those circumstances are, in turn, quite heavily influenced by bad luck (as they are). Although those difficulties can be assumed away for the purpose of the argument presented here, it should be noted that many, if not all, luck egalitarians would also independently oppose such socioeconomic inequalities.⁵⁵ However, under the assumptions stated here, the responsibility-sensitive policies do not express a problematic meaning about those affected by them.

Consider, then, the third kind of disrespect. On Eidelson’s account “discrimination is intrinsically objectionable when it is basically disrespectful of the personhood of those who are discriminated against.” Eidelson lists two aspects of such moral personhood: a person’s moral worth and autonomy.⁵⁶ The first pertains to the equal respect that all of us are owed. Our interests should be respected equally. Specifically, to “respect a person’s equal value relative to other persons, one must value her interests

equally with those of other persons, absent good reasons for discounting them.”⁵⁷ This “implies that respecting someone as a being of equal value also entails *responding to* her status as a bearer of interests with presumptively equal normative weight.”⁵⁸ This is broader than holding problematic mental states because “one can fail to accord someone the respect demanded by her status as a person without taking her to occupy a lower station on an explicit hierarchy of value.”⁵⁹ The question is whether responsibility-sensitive policies give people’s interests unequal weight. It is hard to see that they do. Under the assumption that people have had equal opportunities (or roughly equal opportunities) and made different choices in terms of how much effort they spend taking care of their health, this seems at least to be one plausible candidate for discounting their interests in receiving the same treatment as others.

It is quite clear from Eidelson’s formulation that treating people as equals does not imply treating people similarly. However, it should be noted that whether people’s interests are given adequate weight will probably, even under the assumption employed here, depend on the consequences that the responsibility-sensitive policies allow for. Yet waiting longer or paying a fraction of the costs is unlikely to evoke the same reaction in that regard as, for example, being denied treatment. So, there is a plausible argument that people’s interests are given sufficient weight under the policies described here—but once again, it should be noted that we cannot drop many of the initial assumptions (if any) before this is no longer the case.

Regarding respecting people’s autonomy, the formulations Eidelson uses are very interesting. Here, failure is about failing to treat a person as an individual autonomous being.⁶⁰ Specifically, in forming judgments about Y, X treats Y as an individual if and only if the following two conditions are satisfied⁶¹:

- 1) “X gives reasonable weight to evidence of the ways Y has exercised her autonomy in giving shape to her life, where this evidence is reasonably available and relevant to the determination at hand” (Character Condition).⁶²
- 2) If “X’s judgments concerns Y’s choices, these judgments are not made in a way that disparages Y’s capacity to make those choices as an autonomous agent” (Agency Condition).⁶³

These formulations are very interesting for the present discussion. They point to the importance of respecting people’s decision-making abilities and capacities for making choices. It seems hard to argue that responsibility-sensitive healthcare policies do not do this. It appears that those policies respect autonomy in a much more straightforward way than alternatives that dismiss the notion of responsibility and therefore end up not assigning any importance to the choices made by responsible and capable individuals. Having gone through the three versions of disrespect, we can conclude that disrespect is not what seems wrong with the policies under consideration—at least under the stated assumptions.

Conclusion

This article is the first attempt to formulate and discuss a discrimination objection to luck egalitarian policies in healthcare priority setting. It discussed whether such policies would be considered wrongful discrimination from perspectives offered by the philosophical literature on discrimination, where harm-based and respect-based accounts are very influential.

Drawing on the harm-based literature, it was argued that it is very plausible to consider the policies harmful to those who are affected by them but much less plausible to consider those who are responsible for their health disadvantages a socially salient group. The main reason offered for this conclusion here is that membership of this group is not a clear-cut thing. We would sometimes belong to the group and sometimes not. This strongly suggests that membership, if that is even a meaningful term, of the group is not something that is socially salient and that the policy will not make it so.

A nuancing point should be mentioned in addition to this conclusion. In the harm-based approach to the wrongness of discrimination, some have suggested that the badness of harm depends on the deservingness of those who experience it. A noteworthy example of this is Lippert-Rasmussen’s idea of desert-accommodating prioritarianism.⁶⁴ In this view, harm is worse when it affects the underserving

and those who are worse off. If we (unlike Lippert-Rasmussen) were to understand deservingness in purely prudential terms, then those responsible for their bad health would be less deserving. As per the assumptions, they would not be worse off in general. If we, as Lippert-Rasmussen, utilize a broader understanding of the desert, then the picture would be more mixed. However, if the argument about social salience is correct, then the finer details of this would not need to concern us.

Drawing on the respect-based literature, the conclusions were different. When employing Eidelson's definition of discrimination, which does not have a salience requirement, it seems plausible to consider it a form of discrimination to treat those responsible for their health disadvantage differently from those who are not. However, the policies were, on the other hand, not deemed disrespectful.

This conclusion must not be overstated. The discussion has been conducted under a set of assumptions, which means that it has been assumed that some, but not all, people are responsible for their bad health and that we can distinguish them from those who are not. Furthermore, it was assumed that the choices and risks taken in that regard were taken in a situation with equal opportunities. Finally, the policies in question were implemented consistently, meaning they would affect different groups from various parts of society. This means that the poor implementation of luck egalitarian policies in unequal societies will likely be instances of harmful and disrespectful discrimination. This article is the first attempt at understanding and developing the discrimination objection to luck egalitarianism in health; as such, the conclusions drawn are limited to the theories employed in the discussion, leaving out the question of indirect discrimination. This is often taken to mean that a neutral policy has a disparate impact,⁶⁵ and, although this discussion was only briefly addressed about social meaning, it cannot be adequately addressed here. The article is written in the hope that others will continue and widen this discussion.

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Notes

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