

# A Social Division of Responsibility for Health

Johannes Kniess ([jkniess@princeton.edu](mailto:jkniess@princeton.edu))

(Forthcoming in *Les Ateliers de l'éthique/The Ethics Forum*)

**ABSTRACT:** When is it fair that some people are less healthy than others due to their own individual choices and preferences? In this paper, I explore two alternative answers. The first is a luck-egalitarian account that holds people responsible for choices that society could have reasonably expected them to avoid. I argue that this account is indeterminate and go on to sketch an alternative proposal based on Rawls's idea of a "social division of responsibility." This latter approach connects the notion of responsibility for health to the social conditions under which health-related behaviour is developed.

## INTRODUCTION

The topic of personal responsibility for health tends to elicit two different kinds of reactions. On the one hand, we like to see ourselves as masters of our own fates. When we exercise too little or drink too much or fail to follow our doctors' advice, it's only natural to think that we must assume responsibility for ending up with worse health and longevity than others who have been more prudent. From this point of view, choices and preferences appear to justify (or at least excuse) inequalities. On the other hand, many of us believe that large social inequalities in health should be eliminated or at least reduced. Think of the city of Glasgow, for example, where average life expectancy in some neighbourhoods trails that of others by decades (Marmot, 2007, p. 1153). Even people who find nothing objectionable about large inequalities in income or wealth are often shocked by these forms of inequality in health, regardless of whether these came about by differences in health-related behaviour (cf. Daniels, 2008, p. 29). Hence our two intuitions may sometimes stand in conflict, prompting us to ask the following general question: *when are health inequalities that result from individual choices or preferences fair?*

Now, it is important not to overstate the causal impact of behavioural patterns on inequalities in health. In his famous Whitehall studies, for example, Michael Marmot (2004, p. 45) calculated that "aspects of lifestyle account for less than a third of the social gradient in mortality."<sup>1</sup> And yet lifestyle diseases—such as smoking- and obesity-related conditions—do constitute a major source of premature mortality and avoidable morbidity. It is also widely thought that they harbour the biggest potential for improvements in population health (e.g., Schroeder, 2007). As a result, the notion of personal

responsibility is increasingly invoked by health authorities to encourage healthier lifestyles. A recent trend in health-care policy, for example, is to create reforms that delineate the kinds of behaviour that health-care recipients ought to avoid, and which in some cases even make access to certain medical services conditional upon compliance (Schmidt, 2007; Daniels, 2011).

If personal responsibility has been in the minds of policymakers, the same can be said of political theorists. Indeed, much of the literature on justice and equality in the last three decades has revolved around this often-elusive concept. Many observers have interpreted this surge of interest as a reaction to John Rawls's theory, which, though hugely influential, hardly discusses the topic (e.g., Kymlicka, 2002, ch. 3). As is well known, the difference principle instructs us to improve the position of the worst off, seemingly without regard to their own role in ending up among the least advantaged. Under the influence of Ronald Dworkin's pioneering writings, however, many came to think that a theory of justice must somehow hold individuals accountable for the outcomes of their own choices and preferences. The general position of those who have put the idea of responsibility at the heart of their egalitarian theories of justice has come to be known as luck egalitarianism.

In this paper, I aim to answer our question regarding the fairness of health inequalities caused by individual choices and preferences by contrasting Rawlsian and luck-egalitarian views of responsibility. I am here primarily interested in *substantive* responsibility, which I take to be the propriety of a given benefit or burden falling on an agent. To be responsible for one's health-related behaviour in this sense means that one cannot complain about the outcomes of said behaviour. In the first part of the paper, I focus on a recent version of luck egalitarianism, developed, among others, by Shlomi Segall, which suggests that people are responsible for those imprudent health-related choices that we could have reasonably expected them to avoid. I argue against this intuitive yet misleading way of thinking about personal responsibility. My issue is not so much with the idea that a choice or preference is inequality excusing when an individual could have reasonably avoided it, but rather with the specification of our "reasonable expectations." Here, I claim we must appeal to more fundamental notions of justice than luck egalitarians have hitherto provided.

In a second step, then, I aim to say something more positive about the place of responsibility in distributive justice. By drawing on Rawls's idea of a "social division of responsibility," I argue that we cannot know when people are responsible for the outcomes of their health-related behaviour until we examine the social conditions under which they develop preferences and make choices. If people make imprudent health choices against a background of distributive unfairness, we should not take their choices to render their worsened health and longevity just. This may be seen as a reversal of the intuitive view on the relationship between justice and responsibility: we do not establish which inequalities are fair by looking at what people are responsible for, as luck egalitarianism suggests, but instead define the role of personal responsibility through a theory of what justice requires.

## LUCK-EGALITARIAN JUSTICE IN HEALTH

Luck egalitarianism is a relatively recent view in the history of political thought, and, as such, it generates significant disagreement as to how it is best understood. At its core, however, luck egalitarianism is held together by the belief that we should not be worse off than others through no fault or choice of our own. Other things being equal, we should not bear substantive responsibility for being disadvantaged by what Dworkin (1981) calls “bad brute luck.” For instance, it would be unfair to enjoy worse health and longevity than others due to an incurable genetic illness. It wouldn’t be unfair, however, if our worse health status were due to our own choices and preferences.

A key question is how to specify and separate these ideas; that is, how to locate the appropriate cut between chance and choice. It is increasingly recognized that luck egalitarianism must move beyond a crude or “inflated” view, according to which justice requires that we bear any disadvantage that arises from our choices (Stemplowska, 2013). More recent and sophisticated versions of the theory emphasize that choices must be made against some background of adequate opportunities in order for the resulting disadvantage to be just. In this context, an important development in the literature is the appeal to a “reasonable avoidability” criterion (e.g., Arneson, 1997; Vallentyne, 2002; Sandbu, 2004; Elford, 2012). The general idea here is that people should be responsible only for the outcomes of choices they could have reasonably avoided. There are, of course, different ways of understanding this idea, and in this paper I will explore three possible interpretations. But I shall focus primarily on the account developed by Shlomi Segall (2009; 2012), which I take to be the most clearly articulated version of the reasonable-avoidability criterion. It is, furthermore, an account developed explicitly as a theory of justice in health and therefore the most comprehensive luck-egalitarian treatment of the subject to date.

Segall’s (2009, p. 20) proposal is to interpret brute luck as “the outcome of actions (including omissions) that it would have been unreasonable to expect the agent to avoid (or not to avoid, in the case of omissions).” Expectations are here understood in a normative sense: self-inflicted health deficits are only unfair, on this view, if society could have reasonably (that is, rightly) expected the agent to act more prudently. This is an advance over simpler versions of luck egalitarianism that simply hold people substantively responsible for choices they could have avoided or for outcomes they could have foreseen. For example, imagine a resident of California who could, at considerable cost to herself, move to a different state to avoid the risk of earthquakes. Because it would be *unreasonable* to expect the Californian to move, Segall argues that we should not hold her substantively responsible for any health-related consequences were an earthquake to occur.

A particularly attractive feature of this account is that it does not ask whether it is reasonable for an *individual* to avoid a choice, but whether *society* could reasonably expect that individual to avoid it. For example, take the nurses who enlist to care for Ebola patients during a public-health crisis. From an individual point of view, the nurses would be substantively responsible were they to accidentally contract the disease, since they could have reasonably avoided this health-threatening line of work. From a societal perspective, however, it might be unreasonable to hold the nurses individually responsible for the choice to enlist. After all, they might be simply helping to fulfil society's collective duty of assistance to the needy, for which nurses should not be penalized. To my mind, this is an important and underappreciated feature of the theory. It exemplifies a growing awareness among luck egalitarians about the necessity of thinking about substantive responsibility against a background of societal rights and duties (e.g., Stemplowska, 2009; Eyal, 2006).

But the example also hints at the necessity of providing an account of what precisely those rights and duties are. The nurses' choice may not be reasonably avoidable if they were helping to discharge societal obligations of justice; but perhaps we would consider it reasonably avoidable were it supererogatory. In the latter case, they would be substantively responsible for the ensuing health risks, no matter how praiseworthy their behaviour. In short, to know which inequalities in health are just, we need to know what kind of health-related behaviour we can reasonably expect people to avoid. But to know that, in turn, it seems that we require a background theory of what we owe to one another as a matter of right. Perhaps surprisingly, Segall (2009, p. 21) disagrees:

The luck egalitarian need not provide any further independent criteria by which to judge what sort of conduct individuals ought to bear on their own. She simply states that her aim is to level inequalities that result from such [not reasonably avoidable] conduct, *whatever conduct precisely that might be*.

Although Segall admits that this renders his reasonable-avoidability criterion ambiguous and indeterminate, he argues that this "ambiguity could also be a source of strength. The strength of the 'reasonable avoidability' criterion is that it can give due consideration to the changing circumstances of each case" (2009, p. 22). Hence, we decide what is reasonable on a case-by-case basis. He provides several examples of the following ilk: it might be reasonable to expect people camping on the slope of an active volcano to move elsewhere to avoid being endangered, but it would be unreasonable to expect the same of residents of California, who run a similar risk by living on a geological fault line. It might be reasonable to expect a woman with high risks of serious childbirth complications to avoid pregnancy, but it would be unreasonable to expect the same of a healthy woman. China's one-child policy might be reasonable under "extreme" circumstances, but not under "normal" ones. And so on (Segall, 2009, p. 21-22).

These examples reveal what we might call an *intuitivist* approach. By this I mean an approach characterized by two features: an appeal to common-sense morality and the eschewal of general principles to define what ought to count as reasonably avoidable. The intuitivist proposes to settle questions of substantive responsibility by consulting our intuitions on a case-by-case basis. But there are at least two obvious dangers here. For one thing, our intuitions on different cases may pull us in opposite directions. Just think of the moralistic, and often lopsided, expectations that so permeate our contemporary political discourse on responsibility for health. Overeating or drug taking, for example, are commonly seen as avoidable and therefore inequality excusing, whereas daredevilry in sports is seldom seen in the same light (cf. Wikler, 2004, p. 129). Of course, an intuitivist may on proper reflection reject these inconsistencies. But in the absence of a principled way to define what sort of behaviour we can reasonably expect of one another, the theory runs the risk of replicating them. Worse still, our intuitions on *individual* cases may not be very clear. For, to adequately judge whether a person could have avoided a choice, we need to know more about that person's circumstances, the set of options that the person faced, their relative costs, and so on.

The intuitivist approach does little to identify and assign responsibility in light of structural factors that make compliance with some prudential standard easy for some, but hard for others. As is well documented in the empirical literature, the prevalence of behavioural risk factors follows a social gradient, with healthy lifestyles becoming more common as one climbs up the socioeconomic ladder (Marmot, 2004; Wilkinson, 1996). Social epidemiologists have distinguished at least three major ways in which the social environment can influence individual behaviours: by shaping norms and enforcing patterns of social control, by providing the opportunities and resources to engage in certain behaviours, and by reducing or producing stress for which certain behaviours can be coping strategies (cf. Berkman and Kawachi, 2014, p. 8).

Take the influence of norms. Through longitudinal studies, researchers have been able to observe that behavioural patterns are passed on through the family, culture, and social class from an early age on (Lynch, Kaplan, and Salonen, 1997). A striking example of the role of environmental opportunities is the phenomenon of "food deserts" in impoverished American city-centres, where it is significantly more difficult to avoid an unhealthy diet because fresh produce is not as available and affordable as it is in better-off neighbourhoods (Beaulac, Kristjansson, and Cummins, 2009). Examples of other resources that have been shown to have a causal impact on health-related behaviour are education, information, and knowledge, which, again, are unequally distributed in society (de Walque, 2007; Mirowsky and Ross, 2003). Finally, consider health-threatening behaviours that are associated with the relief of stress. Smoking among low-income women, for instance, has been identified as a resource to cope with material pressures and responsibilities to care for others (Graham, 1993). These examples are not exhaustive, and we may not yet fully understand all mechanisms linking social background conditions to lifestyle choices. Nevertheless, there is little doubt that individuals do not make choices in a vacuum.<sup>2</sup>

It is hardly surprising, then, that “poor people behave poorly,” as a much-cited study puts it (Lynch, Kaplan, and Salonen, 1997). The relevant normative question is whether these background factors can make a person less substantively responsible for his or her poor health choices—that is, whether we could reasonably expect a person to avoid them. When a given obstacle to a healthy lifestyle is obviously a matter of bad brute luck, the answer will surely be positive. But what if the answer is less clear? For example, how poor must a person’s educational opportunities have been for society to judge that that person could not have reasonably avoided adopting an unhealthy diet? The answer is not obvious, and it doesn’t help that Segall’s theory suggests a binary attribution of responsibility, according to which certain choices and preferences are either reasonably avoidable or not (cf. Knight, 2011, p. 79).

Part of the problem is epistemic in nature: we may not fully know or understand the structural impediments facing a person who is trying to conform to a given prudential standard. But even more troubling is the normative uncertainty inherent in the intuitivist approach. Since only *unfair* disadvantages should influence our societal expectations such that an imprudent choice doesn’t render the resulting inequality in health just, we need to know which disadvantages are unfair. Segall, of course, argues that a disadvantage is unfair when it is the result of an individual choice that was not reasonably avoidable. But, at this point, it becomes evident that the argument is circular unless we can appeal to independent criteria to define reasonable avoidability.

So, let me now turn to a second interpretation of reasonable avoidability, one that might provide such independent criteria. A plausible way to specify the reasonable-avoidability criterion is to define some form of *decent minimum* to describe the conditions under which people’s choices can be considered inequality excusing. Martin Sandbu (2004, p. 297), for instance, has suggested that there is “a level of social, economic, and cultural inclusion to which we think every person in the society is entitled to. Such entitlement concerns, if we accept them, give us reasons to put a lower bound on what prospects it is reasonable to demand that people turn down only at their own risk.” Similarly, Gideon Elford (2012, p. 450) argues that a person’s options are unreasonable when they entail “consequences that are incompatible with a decent standard of living.” And even Segall himself has suggested, in later writings (2012, p. 330), that it is unreasonable to expect agents to avoid actions that they have a “vital interest” in exercising. However precisely it is fleshed out, a decent minimum would allow us to identify cases where it would be unreasonable to hold people responsible for their imprudent health choices in virtue of the options they faced. Take, for instance, the issue of food deserts and food poverty. We cannot fault somebody for choosing an unhealthy diet if the cost of nutritious food were so high that it would rule out the satisfaction of other basic needs. In other words, people should not have to choose between buying fresh vegetables and paying the gas bills.

This way of interpreting the reasonable-avoidability criterion is appealing, and superior to the intuitivist approach. But it also raises a further question about the precise content of the decent minimum. Clearly, there is much disagreement about what people

are entitled to as a matter of justice, and the approaches mentioned above fail to specify what exactly these entitlements are or what standard of living we should take as a baseline. This amounts to a recognition that luck egalitarianism still requires a fully fledged “auxiliary theory of when prospects are reasonable” (Sandbu, 2004, p. 296). So, rather than *providing* a theory of responsibility and justice in health, the reasonable-avoidability criterion still *presupposes* a theory of justice to guide us in cases where it is not intuitively clear whether a choice or preference was reasonably avoidable.

Furthermore, the decent minimum approach raises a question about inequalities in health caused by behaviour exercised against a backdrop of adequate but unequal opportunities. Imagine that a person has faced relatively poor opportunities to exercise—say, because that person lives in a neighbourhood with few parks and recreational facilities—but that his or her options are nonetheless just above some specified threshold. It would seem unfair, other things being equal, if, as a result, that person’s health status were lower than that of people in better-off neighbourhoods (and, we could add, incompatible with the luck-egalitarian idea of neutralizing the effects of bad brute luck). Hence the decent minimum approach seems at best an imperfect way to define our reasonable expectations.

At this point, someone might object that it is not necessary to provide a full normative account of the appropriate conditions for choice. For a third way to interpret the reasonable-avoidability criterion is to define our expectations in an *epistemic* way. Instead of developing a theory of the social conditions under which it is sufficiently fair to hold people responsible for their health-related behaviour, we may simply judge people according to certain conventional standards. In other words, we could reasonably expect people to act at least as prudently as others who are in similar circumstances. This, at any rate, is a possibility that has been put forward by John Roemer (1993) as a “pragmatic theory of responsibility for the egalitarian planner.” His suggestion is to group people together in terms of shared socioeconomic and genetic characteristics, thus identifying different “types.” People are then assigned different “degrees of responsibility” depending on the extent to which their health-related behaviour departs from the typical behaviour of their respective type. For instance, a chain-smoking male steelworker might have a degree of responsibility for developing lung cancer comparable to that of a female college professor who smokes only occasionally. If the college professor smoked the *same* amount as the steelworker, however, she would be displaying behaviour that is rather uncommon for her type. From this we’d be encouraged to suppose that she has had a greater degree of choice and therefore should be taken to bear *more* substantive responsibility for developing cancer than the steelworker (Roemer, 1993, p. 151).

One immediate difficulty with this proposal lies in the determination of relevant types, for this already presupposes a judgment about what factors undermine responsibility. More factors entail ever more fine-grained types. Taken to the extreme, this theory may arrive at groups of one, making any assignment of responsibility impossible. But even if we assume some satisfactory way of dividing people into types, it is implausible

to think that our responsibility for some imprudent behaviour would depend on the statistical distribution of said behaviour. According to Roemer's own example, statistical inequalities in smoking rates between the sexes are in part explained by unjust gender norms: traditionally, a social stigma was attached to women smoking in public. If fewer women smoke because they are denied a liberty that men can take for granted, then a female college professor who smokes as much as her male colleagues is punished, in Roemer's account, for disregarding unjust social conventions. But this cannot be right. Whether we are substantively responsible for our actions should not depend on unjust social conventions.

Now, to be fair, Roemer's proposal is best understood as a rough guide to policy-making, and as such it might prove useful in many instances. Yet ultimately it cannot replace a normative theory about the sorts of prudential standards we should set as a society. In order to specify the ambiguous notion of a reasonable expectation, we still need to appeal to more fundamental notions of justice than any of the approaches we have thus far considered have provided.

## **A SOCIAL DIVISION OF RESPONSIBILITY**

Luck egalitarianism, I mentioned at the outset, has often been portrayed as a reaction to the purportedly inadequate discussion of responsibility in Rawls's work. Although *A Theory of Justice* contains sophisticated arguments against desert as a distributive principle, it is true that its positive claims about the proper place of individual responsibility seem underdeveloped. Nevertheless, it would be wrong to infer from this that it has nothing useful to contribute or, for that matter, that luck egalitarians have simply taken Rawls's underdeveloped ideas to their logical conclusion. In this section I want to explore the Rawlsian notion of a social division of responsibility and apply it to our question about health inequalities caused by individual choices or preferences. As I hope to show, the model is not only plausible and coherent in itself. It can also be used to address the question that the reasonable-avoidability approach left unanswered—namely, the question about what sort of health-related conduct society can reasonably expect individuals to avoid.

As is well known, Rawls's project is that of specifying principles of justice to regulate a system of social cooperation among free and equal people from one generation to the next. Justice and injustice, on this view, are features of social institutions—the basic structure of society—rather than judgments about distributive states of affairs as such. In essence, the social system is just when the basic structure regulates the distribution of benefits and burdens of social cooperation in ways that could be justified to all members. For Rawls, this is both measured by and achieved through the distribution of so-called *primary social goods*: all-purpose resources such as liberties, opportunities, and income. Provided a fair distribution of these goods, Rawls says, justice obtains.

But even with a fair distribution of a good like income, say, people can differ in their abilities to satisfy their preferences or to achieve welfare. Imagine, to take Rawls's example (1999, p. 369), that one person is content with a diet of milk, bread, and beans, while another cannot do without expensive wines and exotic dishes. Let's further assume that the latter never chose her sophisticated preferences, but rather was raised to have them, and could not change them even if she wanted to. If we deny that she is therefore entitled to more resources—as Rawls does—then the use of primary goods appears to render some people worse off through no fault or choice of their own, as it doesn't compensate for the bad brute luck of having unchosen expensive tastes. Here, the theory stands in contradiction with the intuitions that motivate luck egalitarianism. But in response to those who take issue with this outcome, Rawls argues that the viability of a fair system of social cooperation relies on the capability of its members to take responsibility for their ends. As he puts it, his conception of justice

includes what we may call “a social division of responsibility”: society, citizens as a collective body, accepts responsibility for maintaining the equal basic liberties and fair equality of opportunity, and for providing a fair share of the primary goods for all within this framework; while citizens (as individuals) and associations accept responsibility for revising and adjusting their ends and aspirations in view of the all-purpose means they can expect, given their present and foreseeable situation. This division of responsibility relies on the capacity of persons to assume responsibility for their ends and to moderate the claims they make on their social institutions in accordance with the use of primary goods. Citizens' claim to liberties, opportunities and all-purpose means are made secure from the unreasonable demands of others (Rawls, 1999, p. 371).

These remarks require some unpicking. It is not immediately obvious, for instance, in what way people can take responsibility for their ends and preferences, or whether Rawls is advancing metaphysical claims about the control we exert over our choices. It is also not entirely clear what makes a demand “unreasonable.” Before I turn to these questions, however, let me lay out the general structure of this social division of responsibility as it applies to the domain of health. The first thing to note is that society's responsibility to ensure the justice of the system is logically prior to the individual's, for the latter is meant to adapt to the former. Indeed, what society owes the individual can be established independently. As already mentioned, justice demands a fair package of primary goods, including liberties, opportunities, and resources like income and wealth.

It would not betray the spirit of the theory, I believe, if we added to this package a claim to what we might call “the social bases of health.”<sup>3</sup> Although Rawls himself saw health as a natural good, one that is primarily determined by genetic factors, there is now little doubt that social arrangements take centre stage in shaping the level and distribution of health and longevity among members of a society. The “social determinants of health”—factors such as education, housing, income, social status, and workplace conditions—profoundly affect our opportunities to live a healthy life, far outweighing the role of genetic factors (e.g., Marmot and Wilkinson, 2005). These determinants, as I understand them, are features of the basic structure or of the situation of

individuals in relation to it. Hence, much like with the distribution of the other primary goods, justice demands a fair arrangement of the social conditions that set the background to our health-related choices. Although it would go beyond the scope of this paper to discuss what precisely a fair distribution of the social bases of health would look like—for instance, whether it required equality between social positions or rather allowed inequalities along the lines of difference principle—I shall take it for granted that Rawls’s theory could be expanded in this way to make judgments about unjust social inequalities in health.<sup>4</sup>

Against this backdrop, we can now specify what kind of health-related conduct society can reasonably expect its members to avoid. We cannot reasonably expect those who have been dealt a bad hand to adopt the healthy lifestyles of those who have been more fortunate, since taking these choices to be inequality excusing would ignore and thereby entrench the underlying influence of an unjust basic structure. Yet provided someone has been given a fair share of primary goods—including the social bases of health—the way that individual makes use of them in pursuing goals and ambitions becomes his or her responsibility. If someone chooses a health-threatening lifestyle in a just society, that choice may be inequality excusing. In short, the model suggests that health inequalities are unfair when they stem from individual health-related conduct that is developed under conditions of social disadvantage, defined in terms of shortcomings of primary goods. The same is not true of those inequalities that result from individual choices and preferences that go beyond what is owed to all as a matter of justice. Here, we rightly expect individuals to bear responsibility for their actions.<sup>5</sup>

Rawls writes that the social division of responsibility presupposes an ability on the part of the individual to adapt and adjust his or her ends in light of the share of primary goods that individual can reasonably expect. On the face of it, it may seem implausible to stipulate such an ability. Imagine, for example, a person who is among the better-off members of society, but who is born with a risk-loving nature and therefore chooses to engage in dangerous sports. Someone else, equally well off with regard to her share of primary goods, develops an addiction to cigarettes as a child and cannot kick the habit. If these individuals do not exert direct control over their health-related conduct (that is, if they cannot adapt their preferences), is it really plausible to hold them responsible for it? If not, should we agree with the luck egalitarian in considering their poorer health and longevity unjust? To understand what is at stake here, it will be useful to introduce a distinction between two different senses of responsibility. Thus far we have considered personal responsibility primarily as *substantive* responsibility: the idea that people can be held liable for the outcomes of their choices in a way that affects the justice of distributions of benefits and burdens. But as T. M. Scanlon has argued, this sense of responsibility can be contrasted with a different sense, which he calls responsibility as *attributability*. Here, responsibility means that “some action can be attributed to an agent in the way that is required in order for it to be a basis for moral appraisal” (Scanlon, 1998, p. 248).

It would be inappropriate, in the example I just gave, to blame the two individuals for their health-threatening conduct. Since their preferences are outside their control (*ex hypothesi*), these cannot be attributed to them as a moral judgment of their character. However, this sense of responsibility does not necessarily entail a judgment of substantive responsibility, and this is where Rawls's view is so easily misunderstood. In assuming the capacity to revise and regulate their ends, Rawls is not suggesting that those with "expensive tastes" are responsible in the attributive sense for their preferences (much less is he advancing a metaphysical claim about freedom of the will). Instead he is proposing a conception of the person that is "at least implicitly accepted as an ideal underlying the public principles of justice" (Rawls, 1999, p. 370). In other words, Rawls is claiming that a conception of the person that includes the ability to revise and adjust one's ends would be accepted by the members of a fair social system that endures over time. To ensure the fairness of the basic structure and to protect individual shares of primary goods from unreasonable demands, members would agree to a system in which they can be held substantively responsible for their choices and preferences, even if these cannot be attributed to them (cf. Blake and Risse, 2008, p. 181-186).

Compare this view to Segall's. Intuitivism, we said, appeals to common-sense morality, which tends to conflate both senses of responsibility. When a person is blamed (or praised) for a voluntary choice, it is commonly assumed that he or she ought to bear the resulting burdens (or benefits), whatever those may be. From this point of view, it looks intuitively unfair that a person could be worse off with regard to his or her health due to factors for which that individual cannot be blamed, as in the examples of the well-off smoker and the risk taker. But note how this intuition is driven by common-sense morality and a focus on particular cases. When we step back to consider the theory as whole, the Rawlsian notion of responsibility is nevertheless plausible and coherent. For if what we owe to each other is to be factored into our judgments of substantive responsibility—as Segall and other luck egalitarians recognize in principle—then it is not enough to know whether a person's choice can be attributed to him or her. We must also know what effects the assignment of substantive responsibility has on the justice of the social system as a whole.<sup>6</sup>

Having sketched the idea of a social division of responsibility for health, I will now turn to two more practical objections. Health inequalities caused by differences in individual behaviour can be fair, I argued, only when that conduct is developed under fair conditions, as measured by the distribution of the social bases of health and other primary goods. Taken to its conclusion, this argument suggests that where there is no justice, there is also no (substantive) responsibility. The disadvantaged in an unjust society are therefore let off the hook, so to speak, no matter what they do or don't do to look after their health. Yet this will strike many people as implausible, for even under the most unfavourable circumstances, we commonly think that individuals bear at least *some* responsibility for their choices and preferences.

This objection arises because we haven't said much yet about the practical application of the theory to realistic circumstances. Rawls introduces the social division of responsibility as a model within what he calls "ideal theory," which assumes favourable conditions and full compliance to the principles of justice. But what shall we make of it in societies like the ones we live in, societies that are not ideally just? The objection in the preceding paragraph assumes an implausible dichotomy, according to which people are either fully responsible for the outcomes of their choices and preferences or, on the contrary, bear no substantive responsibility at all. However, these two extremes are plausible, if at all, only under conditions of perfect justice or radical injustice, respectively. Most societies fall somewhere in between these extremes. Hence, in a more plausible application of the model to realistic circumstances, we would make judgments of substantive responsibility that are scalar in character. That is, we might want to assign "degrees of responsibility," to borrow Roemer's phrase, according to the distributive fairness of the backdrop to our health-related choices. I take this view to be well aligned with our considered judgments: the appeal of distributive outcomes that reflect people's manifested choices generally declines as the injustice of society increases, in the same way that we are less inclined to accept the results of a game, the more we have reason to believe that the rules have systematically disadvantaged its losers.

Consider, finally, a different practical objection to the model I have just sketched. I suggested that our degree of substantive responsibility should reflect the distributive fairness of the conditions under which we make our health-related choices. But this seems to have a counter-intuitive implication: the more disadvantaged a particular person is, the less appropriate it seems for the state (or some other relevant agent) to appeal to that person's responsibility for his or her own health-related behaviour. For to appeal to someone's responsibility seems to imply that that person bears responsibility in the first place. If this is correct, however, then one might think that governments should have nothing to say about the poor health choices of their citizens, and in particular those of the worst off, who often display the most harmful patterns of health-related conduct.

Given that lifestyle diseases are increasingly a leading cause of death in many parts of the world, this objection would have far-reaching implications. It seemingly suggests a limited role for public health approaches to encourage behaviour change. However, the objection moves too quickly. There is a relevant difference between holding a person responsible—either in the substantive way or the attributive way identified by Scanlon—and appealing to that person's responsibility—for instance, as part of a public health campaign. In this latter sense, responsibility can be understood merely as causal involvement, as a recognition of the fact that there are choices a person could make to help bring about a given outcome. Public health initiatives that discourage smoking or heavy drinking, for example, may appeal to people's casual ability to change their behaviour, without thereby necessarily blaming them or making them bear the costs should they fail to do so (cf. Waller, 2005, p. 180; Wikler, 2004, p. 131; Daniels, 2011, p. 275).

What is more, public health efforts aimed at lifestyle diseases are arguably even part of what justice requires by way of a fair distribution of the social bases of health. As Norman Daniels (2011, p. 277) has pointed out, for example, efforts to curb smoking are set against a historical background in which governments subsidized tobacco production, failed to regulate advertisement by tobacco companies, and so on. We may see this as a societal failure to create fair conditions under which individuals form their health-related conduct. Now, to be sure, there are limits to what governments may do to encourage or discourage health-related choices and preferences. For one thing, not all behaviour-change campaigns are successful, and there is a real risk that individuals come to overestimate their own abilities to change their lifestyles. This can lead to disappointment and frustration, or, even worse, stigmatization by others, with ultimately detrimental effects on individual health (cf. Wikler, 2004, p. 131). There are also obvious worries about autonomy and paternalism. But none of this rules out the use of appeals to personal responsibility as a policy tool, nor the idea that these can be separated from discussions of substantive responsibility, which have been the primary focus of this paper.

## CONCLUSION

Let me conclude by contrasting, in a more general spirit, the two different ways of thinking about responsibility for health that this paper has discussed. We began by considering a conception of justice that revolves around the idea of personal responsibility. For luck egalitarians, inequalities between individuals are fair when they track choices and preferences that those individuals are responsible for, in the relevant sense. But what sense is that? For Shlomi Segall and others, inequalities in health are fair when they are the result of choices and preferences that society could have reasonably expected the individuals in question to avoid. This proposal is not implausible, but it raises a further question—namely, what sort of health-related conduct society can reasonably expect from individuals. In its inability to provide a principled way to settle this latter question, the reasonable-avoidability approach reflects a basic problem in much of our intuitive thinking about responsibility.

The problem might be put as follows. According to the old adage, justice consists in “giving each person his or her due.” But this phrase allows for at least two different interpretations. The first, which luck egalitarians embrace, is that justice in the distribution of health can be established if we keep track of what each person is substantively responsible for. The idea is intuitively plausible: by looking at what individuals are due—what benefits and burdens are rightly theirs to bear, given the choices they have made—we arrive at judgments about the fairness of distributive states of affairs. But, of course, knowing what individuals are responsible for is no simple matter. With regard to people’s health-related behaviour, we know that unequal socioeconomic positions influence our choice-making and choice-following abilities. We shouldn’t hold people responsible for their poor health choices if these are made under conditions that are *unfair*—that is, if people have a right to better conditions for choice. If this is

correct, however, asking what we can reasonably expect from people is not a way to determine what is fair—rather, we must know what fairness requires to know what we can reasonably expect from people.

And so, the idea of a social division of responsibility reverses the relationship between responsibility and justice implicit in luck egalitarianism, and centres on the justice of the social arrangements under which we make choices and develop preferences. From this point of view, giving each person “his or her due” means providing a fair package of primary goods, including, as I have argued, the social bases of health. If we are to assign substantive responsibility in a way that takes into account people’s rights and duties, then we must establish what society owes individuals first.

Naturally, there is still a place for personal responsibility within this way of thinking about justice. If people have been given their fair opportunities to be healthy, but nonetheless act or develop preferences such that they are rendered worse off than they could have been, it is not unreasonable to treat them as substantively responsible for their situation. And furthermore, even when some have *not* had their fair opportunities to be healthy—as is often the case in our non-ideal societies—there might be reasons to invoke the idea of personal responsibility as an acknowledgement of their causal powers to improve their own health. Asking individuals to take charge of their lives can be seen, in a very pragmatic way, as a means to improve population health. In this way, the idea that people are authors of their own fates may be reconciled with the thought that it is not always fair to expect them to bear the burdens of their imprudent choices.

## NOTES

<sup>1</sup> In other words, when we control for behavioural risk factors, we still observe major inequalities in health, which suggests that the same choices can lead to different outcomes for different people.

<sup>2</sup> There are two main challenges in establishing a causal relationship between social-background factors and health behaviours: reverse causation (“Do disadvantaged people choose poor health behaviours or does poor health behaviour lead to social disadvantage?”) and confounding (“Do disadvantaged people smoke because smoking and disadvantage are both determined by a third factor, such as intelligence?”). It is hard to deny that some part of the association is due to these factors. However, a multitude of studies—including the ones mentioned above—have managed to control for these effects by employing methods such as natural experiments and longitudinal designs. Thus, in a seminal early survey of the field, Link and Phelan (1995, p. 83) conclude: “While medical sociologists and social epidemiologists have not denied the possibility that illness affects social conditions ... [.] they have, at the same time, demonstrated a substantial causal role for social conditions as causes of illness.”

<sup>3</sup> The analogy here is with another Rawlsian primary good: the social bases of self-respect. Self-respect cannot be (re-)distributed directly, but the basic structure influences individual holdings through the distribution of other goods—namely, equal basic liberties, fair equality of opportunity, etc. Something similar applies to health: we can aim at a fair social distribution of health only by ensuring that other important goods are distributed fairly.

<sup>4</sup> It may be useful to contrast the approach sketched here with the most prominent theory of justice in health, Norman Daniels’s (2008). Although Daniels also embeds his account within Rawls’s

theory and, furthermore, defends similar views with regard to personal responsibility (Daniels, 2011), his approach differs in some respects. Rather than treating the social bases of health directly as a primary good, Daniels argues that good health is a precondition for the realization of Rawls's principle of fair equality of opportunity. Due to the structure and the lexical priority of the equality-of-opportunity principle, his view seems to require equal opportunities for health and to rule out societal trade-offs between health and other goods governed by the difference principle, such as income or wealth. My view here is more modest in this regard, in that it allows for the possibility that a just society may not offer strictly equal opportunities to be healthy—for example, if that implied considerable losses in other primary goods. The precise weighting of the different elements of an index of primary goods is of course an open question within Rawls's theory, and I shall say nothing about it here.

<sup>5</sup> Note that this still requires spelling out what it would mean for someone to bear that responsibility. Our account need not imply the harsh conclusion that we owe *nothing* to those who are responsible for their imprudent health-related behaviour. It may still be the case, for example, that we owe them access to a minimally decent level of health care, but that they bear the burden of their choices and preferences in some other way.

<sup>6</sup> At this point, a luck egalitarian might object that justice obtains not when a social system can be justified to its members, but rather when the effects of bad brute luck are eliminated. I have not provided an independent argument for thinking that the latter view of justice is incorrect, nor, indeed, that the former is correct. Rather, I have sought to show that Rawls's theory includes a conception of responsibility that is plausible and coherent. It is not an objection to it that it cannot accommodate elements of a conception of justice that is foreign to it, even if these resonate with some aspects of common-sense morality. Moreover, the model that I have sketched can help specify the reasonable-avoidability criterion, which in turn is one of the more sophisticated proposals to define substantive responsibility in the luck-egalitarian literature.

## REFERENCES

Arneson, Richard, "Egalitarianism and the Undeserving Poor," *Journal of Political Philosophy*, vol. 5, no. 4, 1997, pp. 327-350.

Beaulac, Julie, Elizabeth Kristjansson and Stephen Cummins, "A Systematic Review of Food Deserts, 1966-2007," *Preventing Chronic Disease*, vol. 6, no. 3, 2009, p. A105.

Berkman, Lisa and Ichiro Kawachi, "A Historical Framework for Social Epidemiology: Social Determinants of Population Health," in Lisa Berkman, Ichiro Kawachi and Maria Glymour (eds.), *Social Epidemiology*, 2nd edition, New York, Oxford University Press, 2014, pp. 1-16.

Blake, Michael and Mathias Risse, "Two Models of Equality and Responsibility," *Canadian Journal of Philosophy*, vol. 38, no. 2, 2008, p. 165-199.

Daniels, Norman, *Just Health*, Cambridge, Cambridge University Press, 2008.

———, “Individual and Social Responsibility for Health,” in Carl Knight and Zofia Stemplowska (eds.), *Responsibility and Distributive Justice*, Oxford, Oxford University Press, 2011, pp. 266-286.

de Walque, Damien, “Does Education Affect Smoking Behaviors? Evidence Using the Vietnam Draft as an Instrument for College Education,” *Journal of Health Economics*, vol. 26, no. 5, 2007, pp. 877-895.

Dworkin, Ronald, “What Is Equality? Part 2: Equality of Resources,” *Philosophy & Public Affairs*, vol. 10, no. 4, 1981, pp. 283-345.

Elford, Gideon, “Equality, Choice, and Alternatives: Why Reasonable Avoidability Matters,” *Ethical Perspectives*, vol. 19, no. 3, 2012, p. 445-468.

Eyal, Nir, “Egalitarian Justice and Innocent Choice,” *Journal of Ethics & Social Philosophy*, vol. 2, no. 1, 2006, p. 1-18.

Graham, Hilary, *When Life's A Drag: Women, Smoking and Disadvantage*, London, Department of Health, HMSO, 1993.

Knight, Carl, “Inequality, Avoidability, and Healthcare,” *IYYUN: The Jerusalem Philosophical Quarterly*, vol. 60, 2011, pp. 72-88.

Kymlicka, Will, *Contemporary Political Philosophy*. 2nd ed., Oxford, Oxford University Press, 2002.

Link, Bruce and Jo Phelan, “Social Conditions as Fundamental Causes of Disease,” in “Forty Years of Medical Sociology: The State of the Art and Directions for the Future,” extra issue, *Journal of Health and Social Behavior*, 1995, pp. 80-94.

Lynch J. W., George Kaplan and Johanna Salonen, “Why Do Poor People Behave Poorly? Variation in Adult Health Behaviours and Psychosocial Characteristics by Stages of the Socioeconomic Lifecourse,” *Social Science and Medicine*, vol. 44, no. 6, 1997, pp. 809-819.

Marmot, Michael, *Status Syndrome: How Your Social Standing Directly Affects Your Health and Life Expectancy*, London, Bloomsbury, 2004.

———, “Achieving Health Equity: From Root Causes to Fair Outcomes,” *The Lancet*, vol. 370, no. 9593, 2007, pp. 1153-1163.

Marmot, Michael and Richard Wilkinson (eds.), *Social Determinants of Health*, Oxford, Oxford University Press, 2005.

- Mirowsky, John and Catherine E. Ross, *Education, Social Status, and Health*, Hawthorne, NY, Aldine De Gruyter, 2003.
- Rawls, John, *Collected Papers*, Samuel Freeman (ed.), Cambridge, MA, Harvard University Press, 1999.
- Roemer, John, "A Pragmatic Theory of Responsibility for the Egalitarian Planner," *Philosophy & Public Affairs*, vol. 22, no. 2, 1993 pp. 146-166.
- Sandhu, Martin E., "On Dworkin's Brute-Luck–Option-Luck Distinction and the Consistency of Brute-Luck Egalitarianism," *Politics, Philosophy & Economics*, vol. 1, no. 3, 2004, pp. 283-312.
- Scanlon, Thomas M., *What We Owe to Each Other*, Cambridge, MA., Belknap Press, 1998.
- Schmidt, Harald, "Patients' Charters and Health Responsibilities," *British Medical Journal*, vol. 335, no. 7631, 2007, pp. 1187-1189.
- Schroeder S., "We Can Do Better: Improving the Health of the American People", *New England Journal of Medicine* vol. 357, no. 12, 2007, pp. 1221–1228.
- Segall, Shlomi, "Health, Luck and Justice Revisited," *Ethical Perspectives*, vol. 19, no. 2, 2012, pp. 326-334.
- , *Health, Luck and Justice*, Princeton, Princeton University Press, 2009.
- Stemplowska, Zofia, "Rescuing Luck Egalitarianism," *Journal of Social Philosophy*, vol. 44, no. 4, 2013, pp. 402-419.
- , "Making Justice Sensitive to Responsibility," *Political Studies*, vol. 57, no. 2, 2009, pp. 237-259.
- Vallentyne, Peter, "Brute Luck, Option Luck, and Equality of Initial Opportunities," *Ethics*, vol. 112, no. 3, 2002, pp. 529-557.
- Waller, Bruce, "Responsibility and Health," *Cambridge Quarterly of Healthcare Ethics*, vol. 14, no. 2, pp. 177-188.
- Wikler, Daniel, "Justice, Socioeconomic Status, and Responsibility for Health," in Sudhir Anand, Fabienne Peter and Amartya Sen (eds.), *Public Health, Ethics and Equity*, Oxford, Oxford University Press, 2004, pp. 109-134.
- Wilkinson, Richard, *Unhealthy Societies: The Afflictions of Inequality*, London, Routledge, 1996.