# Personal Responsibility in Health and Healthcare: Luck Egalitarianism as a plausible and flexible approach to health

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Article accepted for publication in Political Research Quarterly

Please refer to published article: It is available her

Albertsen, A. (2020). Personal Responsibility in Health and Health Care: Luck Egalitarianism as a Plausible and Flexible Approach to Health. *Political Research Quarterly*, *73*(3), 583–595.

https://doi.org/10.1177/1065912919845077

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**Abstract**

*Allocating healthcare resources based on personal responsibility is a prominent and controversial idea. This article assesses the plausibility of such measures through the lens of luck egalitarianism, a prominent responsibility-sensitive theory of distributive justice. The article presents a framework of luck egalitarianism in health, which integrates other concerns of justice than health, is pluralist and is compatible with a wide range of measures for giving lower priority to those deemed responsible. Applying this framework to oral health, the allocation of livers among potential transplant recipients and travel insurance demonstrates that this version of luck egalitarianism is a much more attractive and flexible theory than much of the contemporary discussion allows. This also pertains, to its ability to provide plausible answers to two prominent critiques of harshness and intrusiveness. The discussion also shows that the luck egalitarian commitment to eliminating the influence of luck on people's lives is likely to require substantial redistribution.*

*Keywords: Luck egalitarianism; personal responsibility in health; distributive justice; health justice; Individual responsibility in health; healthcare justice*

## Introduction

Allocating medical resources in accordance with needs informs much contemporary thinking regarding the provision of healthcare (Jensen and Petersen 2017). The increased prevalence of non-communicable diseases has however brought to the fore the alternative rationing criterion of personal responsibility (Golan 2010; Leichter 2003; Minkler 1999; Reiser 1985; Sharkey and Gillam 2010; Schmidt 2009). The recent Global Burden of Disease Study illustrates why: Half the major causes of death are non-communicable diseases (Lim et al. 2013; Murray et al. 2014). Other studies indicate that these diseases claim large proportions of healthcare budgets (Long, Reed, and Lehman 2006; Rasmussen et al. 2004). Allocating health care resources based on personal responsibility is part of a wide range of policies and policy proposals. In Germany, the degree of out-of-pocket payment related to dental care increases for those who have failed to meet a specified frequency for check-ups (Schmidt 2008, 209). In West Virginia families can be disadvantaged by their health insurance company if they miss appointments (Daniels 2011, 267). In the Netherlands personal responsibility as a rationing criterion is a possibility provided by the letter of the law (Tinghőg, Carlsson, and Lyttkens 2009, 203). In Florida, obese people can be denied treatment qua being obese (Eyal 2013). In the United Kingdom, a number of Clinical Commissioning Groups within the NHS have proposed to restrict elective surgery for patients who either smoke or are obese (Pillutla, Maslen, and Savulescu 2018). In many countries, people with alcohol related end stage liver disease must undergo six months of sobriety before they are allowed on the waiting list for an organ transplantation (Dom et al. 2015). Others suggest that this group should be considered ineligible for transplantation (Sample 2005). These proposals seek, in various ways, to make resource allocation sensitive to personal responsibility. The underlying thought is that those who are responsible for their diminished health have a weaker claim on resources that could have aided others.

Responsibility-sensitive policies are controversial, and an extensive literature has

emerged which is critical towards personal responsibility (Andersen et al. 2013; R. C. H. Brown 2013; Bærøe and Cappelen 2015; Denier 2005; Fleck 2011; Friesen 2016; Vincent 2009; Wikler 2002). This article contributes to this discussion by applying luck egalitarianism, a prominent responsibility-sensitive theory of distributive justice, to health and healthcare. The article first presents luck egalitarianism in general, and as a theory of distributive justice in health. It then describes the luck egalitarian framework employed here. The most notable features of this are that it integrates concerns for distributions other than health, is pluralistic in its concern for other values than distributive justice and flexible regarding how to give lower priority to those deemed responsible. Lower priority is used as a shorthand for institutional measures, which treats the claims of some as less strong than the claims of others. These three features set the framework apart from how luck egalitarianism is often discussed in the literature. The framework is then applied to three health-related cases: oral health, allocation of livers for transplants and travel insurance. For each topic the article discusses how we can assess responsibility through an exemption scheme inspired by Roemer. This discussion also highlights important factors mitigating responsibility. Then it is evaluated whether we have reasons to believe that those responsible for their health disadvantage will be unjustly disadvantaged in other spheres of life. Finally, the article poses the question of how we can give lower priority and whether doing so conflicts with other important values. Specifically, it is considered whether the proposed institutional measures are too intrusive in the assessment of responsibility and too harsh towards those deemed responsible. Based on this analysis it is concluded that luck egalitarianism is a much more attractive and flexible theory than much contemporary discussion allows for.

**Luck Egalitarianism in health**

In contemporary debates over distributive justice, luck egalitarianism most clearly stresses the importance of personal responsibility. Luck egalitarians consider distributions as just, when they reflect people's exercises of responsibility and conversely that distributions reflecting luck are unjust

(Arneson 1989; Barry 2008; Cohen 1989; Knight 2009, 2013; Lippert-Rasmussen 2015; Stemplowska 2009). Inspired by Lippert Rasmussen (Lippert-Rasmussen 2001), this article defines the core luck egalitarian claim as follows: Distributions are just, if and only if, people's comparative positions reflect nothing but their comparative exercises of responsibly. As luck egalitarians emphasize personal responsibility, it is unsurprising that we can identify both past and present attempts to apply luck egalitarianism to inequalities in health and healthcare (Albertsen 2015c; Albertsen and Knight 2015; Cappelen and Norheim 2005; Le Grand 2013; Roemer 1993; Segall 2010a, 2012). These attempts have invited a large literature disputing the plausibility of luck egalitarianism in health. Some critiques point to the implausibility of luck egalitarianism in the context of some specific disease or behaviour (M. E. J. Nielsen and Andersen 2014; Feiring 2008; Mailly 2005; Fleck 2011). Other's claim that luck egalitarianism is in general an unattractive theory of health (Ahola-Launonen 2016, 2018; Bærøe and Cappelen 2015; Buyx and Prainsack 2012; Cavallero 2011; Levy 2018, 2019; L. Nielsen 2013; L. Nielsen and Axelsen 2012; Schmidt 2009). Each of these approaches has a distinct weakness. The first branch fails to reflect sufficiently over what lessons the discussion of a specific case provides for luck egalitarianism in health as such. The second branch pays insufficient attention to case specific details. This article departs from how luck egalitarianism is often discussed in the context of health by proposing the following approach.

When evaluating a health disadvantage, we should ask: [1]

i. Is the person responsible for the health disadvantage?

ii. Is the health disadvantage offset by disadvantages in other spheres of life, for which the person is not responsible?

[1] The paper follows most luck egalitarians in the literature by focussing on the distribution of health rather than healthcare (Albertsen and Knight 2015; Le Grand 1991, 112; Segall 2010a, 92; Voigt 2013). Hunter is perhaps the most noteworthy exception to this trend (Hunter 2007). The framework develops arguments made in (Albertsen and Knight 2015)

iii. Do we have reasons beyond distributive justice to refrain from giving lower priority?

The first question asked reflects the luck egalitarian commitment to the moral importance of personal responsibility. The second question follows from an integrationist commitment to take disadvantages in other spheres into account, and the third reflects a commitment to pluralism. If the answer to the first question is affirmative, and those to the two following are negative, we have luck egalitarian reasons to introduce institutional measures assigning lower priority to the person. How we are to assign lower priority is a separate question. The framework is compatible with a wide range of measures to provide lower priority. This framework departs in important ways from contemporary debates over luck egalitarianism in health. Specifically, it moves beyond three narrowing sentiments, which are unfortunately all too frequent in contemporary debates over luck egalitarianism in health.

*Narrowing sentiments in the contemporary debate over luck egalitarianism in health*

This section unfolds how the framework presented above departs from how luck egalitarianism is often assessed and discussed in the context of health. The purpose is to highlight how contemporary discussions have performed a narrowing of the debate, leaving out important possibilities. The section shows that luck egalitarianism in health need not, and indeed often do not embrace these narrower ways of applying luck egalitarianism. The claim is not that every critique of luck egalitarianism contains all these narrowing sentiments, nor that the authors cited believe that these sentiments reflect the only way of discussing luck egalitarianism in health. The claim is rather that these sentiments and their prevalence have exercised a narrowing influence on the debate over luck egalitarian distributive justice in health. They provide a specific way of conducting the discussion over the plausibility of luck egalitarianism. The framework applied here shows what we can gain once we broaden the discussion.

One important narrowing is performed, when luck egalitarianism is applied to health without adequately taking into account the unjust distribution of other important (dis)advantages.

Discussing luck egalitarianism in such a narrow way has led to claims that luck egalitarianism fails to appreciate the various ways social factors undermine responsibility (R. C. H. Brown 2013, 3–4; Daniels 2008, 76; Fleck 2011, 7).[2] Others suggest that luck egalitarians will introduce will introduce responsibility-sensitive measures, which adversely affect those who are worst off (Ahola-Launonen 2016, 460; Cavallero 2011; Ruger 2010, 154). For example, Cavallero suggests that 'A policy of imposing personal liability for option-luck healthcare costs will tend to be regressive in its effects, hitting the worst off the hardest and thus … tending to aggravate the burdens of those who are already unjustly disadvantaged' (Cavallero 2011, 401). Discussing luck egalitarianism in such a way narrows the debate because it reflects what Knight and Albertsen call an isolationist interpretation of luck egalitarianism in health,[3] where the distribution of health/healthcare is evaluated without considering the distribution of other goods, such as wealth and education (Albertsen and Knight 2015). An isolationist theory which considers health in isolation, whereas the alternative, an integrationist approach, considers it alongside other areas of life relevant to justice. As luck egalitarians are often explicitly integrationist (Albertsen and Knight 2015; Segall 2007b, 2010b), there is no reason to make the opposite assumption.[4]

A second narrowing arises when luck egalitarianism is considered as a theory, which narrowly focusses on justice in a way that fails to appreciate other important values. That is that the theory focusses on distributive justice and sets aside other values. Fleck pin-points such a concern when he submits that the responsible could 'make just unlimited demands for very costly, marginally beneficial healthcare' whereas the responsible 'would be denied expensive healthcare that otherwise

[2] However, the luck egalitarian rejection of letting people's lives be affected by factors they are not responsible for, should give us reasons to compensate for such disadvantages. Something which several luck egalitarians have stressed (Albertsen 2015a; Segall 2010a, 92).
[3] Using a terminology employed by Caney in a different context (Caney 2012).
[4] Preda convincingly argues against the isolationist approach to health (Preda 2018)

would provide them with additional years of a reasonable quality of life'. Ruger maintains that luck egalitarians 'differentiate among people *solely* in terms of responsibility for a given health state' (Ruger 2010, 110). A similar move is made when Ram-Timkin asks whether we would 'give absolute priority to 3 children with a rare fatal genetic disease over life-saving medication for 10 adults who failed to maintain a healthy lifestyle?' (Ram-Tiktin 2012, 346). These assessments would only be correct if we care only about distributive justice and set aside other important values, such as beneficence and need. There is no need to do so. Luck egalitarians in general, and luck egalitarians who apply their theory to health, are more often than not explicit about their pluralism (Arneson 1989, 81; Cohen 1989, 906; Segall 2010a).[5] They believe that other values than distributive justice can be important and at some point override the requirements of distributive justice.

The third narrowing sentiment pertains to the kind of consequences envisioned for those deemed responsible for their own bad health. Often denying treatment to those who are responsible for their health disadvantage takes centre stage in this discussion. Fleck remarks that it is 'cruel and inhumane to let such individuals suffer and die in the proverbial hospital parking lot' (Fleck 2011, 15). Vandevelde asks: 'If someone gets into a life-threatening situation due to his own imprudence, should we then abandon him to his fate?' (Vandevelde 2013, 104). Denier, in her discussion of luck egalitarianism, submits that it 'it would be unjust to refuse care to people in need, even if it is clear that they were responsible for their condition (Denier 2005, 233). Daniels describes luck egalitarianism as a theory which 'conclude that we have claims on others for medical assistance only if we are sick through no fault of our own' (Daniels 2008, 76). Venkatapuram states that luck egalitarianism implies that those 'who are ill because of their imprudent choices have to be abandoned' (Venkatapuram 2011, 198). While denying people healthcare is one way of holding them responsible, the narrow focus on this particular way of giving people lower priority overlooks the

[5] For discussion of efficiency and responsibility, see (Andersen and Nielsen 2015)

fact, that there are many ways to ensure that how people fare reflects their exercises of responsibility.[6] It could also be that co-payment, higher insurance premiums or longer waiting time should be introduced. There is ample room for luck egalitarians to prefer such other measures of holding people responsible for their unhealthy choices. It is also the case that luck egalitarians tend to discuss and acknowledge that there are different ways of holding people responsible, rather than focusing only on denying care (Segall 2010a; Albertsen and Knight 2015; Voigt 2013). The framework employed here thus broadens the debate, by applying such a broader notion of giving lower priority.

Departing from these narrowing sentiments, we end up with a framework, which approaches health in an integrationist rather than an isolationist manner and maintains a pluralist approach to distributive justice. It furthermore emphasises, that there are many ways in which we could hold people responsible beyond denying treatment. This framework broadens the debate by leaving behind the three presented narrowing sentiments. Some critiques of luck egalitarianism are only relevant for versions of luck egalitarianism not extended in the mentioned way. The narrowing sentiments give rise to a number of concerns with luck egalitarianism in health, such as the idea that it reflects badly on luck egalitarianism that it denies treatment or ignores social inequalities. The described framework is not vulnerable to such criticisms. However, the framework might be susceptible to other important critiques. Especially two critiques have been prevalent in the general debate over luck egalitarianism in health. The first claims that luck egalitarianism is too harsh towards those, who are responsible for their own poor health (Anderson 1999, 296; Fleurbaey 1995, 40). This will be discussed under the label *the harshness objection.* The second critique asserts that luck egalitarianism requires shameful revelations in the assessment of responsibility. Thus, institutions aimed at realizing luck egalitarian principles of distributive justice are likely to require shameful

[6] This approach is compatible with and inspired by the debate over stakes in the broader luck egalitarian literature (Olsaretti 2009, 2013; Stemplowska 2013). See also, (A. Brown 2005; Couto 2015)

revelations from the people whose (lack of) responsibility is under assessment. The thinking is that implementing policies will require gathering information about people's past behaviours and circumstances (Anderson 1999; Wolff 1998). This will be discussed under the label of shameful revelations. These critiques are not clearly dismantled by the broadening provided by the employed framework. One might suspect and hope that various elements in the framework will strengthen luck egalitarianism also when it comes to dealing with these critiques. But, whether this is the case can only be assessed by applying the framework to relevant cases and compare how it fares. The next section selects cases which provide a proper ground for discussion the questions posed by the employed framework.

**Three cases**

The approach presented above will be applied and discussed across three very different cases: Oral health, distribution of livers among potential recipients and health related travel insurance. The cases are selected because they differ regarding the severity involved and whether they are inside or outside the healthcare system. Allocating livers for organ transplants is a rationing decision inside the healthcare system, which involves very severe outcomes for those who do not receive a liver. Oral health serves as a case with less severe consequences located inside the healthcare system.[7] To limit the extent of the discussion, this case will be considered by assessing caries and the surgical removal of wisdom teeth. The third topic is travel insurance. When people fly for leisure to scuba-dive, ski or scale high mountains, they sometimes find themselves in need of medical care and specialised transportation back home. Travel insurance is discussed because it deals with severe cases outside of the healthcare system.

While space precludes giving a detailed account of the various laws regulating these

[7] 'Less severe' reflects that there are areas of health where the stakes are higher. Clearly poor oral health can seriously affect people's wellbeing (Sheiham 2005, 114–15).

areas across countries some initial observations might be helpful, to understand why these cases are fruitful for the discussion of responsibility-sensitive policies. While clearly related to an important part of our health, oral health services is often institutionally located outside the traditional healthcare system. This means that even in more or less universal welfare states, costs associated with oral health treatment is financed throughout of pocket payment and private insurance (Holst, Sheiham, and Petersen 2001). This approach to oral health places a large burden on those who are disadvantaged through bad oral health, irrespectively of their personal responsibility. Regarding allocation of livers, the case is particularly interesting because a large proportion of those who need a new liver have such a need because of past alcohol consumption (Stell, McAlister, and Thorburn 2004). Alcohol-related liver disease contributes significantly to the global burden of disease (Rehm, Samokhvalov, and Shield 2013). Most countries treat transplant candidates equally, irrespective of how the need arose. In assessing this, it is important to note that we do not have efficiency-based grounds for preferring one group over the other (Burra and Lucey 2005, 496; Trzepacz and DiMartini 2011, 222). This means that if screened properly, we cannot say that a person with a past of alcohol consumption will fare worse than a person without such a past. Regarding travel insurance, the most common institutional arrangement of is that travellers cover or insure against all costs acquired while traveling, regardless of whether they are responsible for the disadvantage, which gives rise to these costs.[8] The following sections addresses these three cases employing the already presented framework. It reflects over the best institutional measure to assess responsibility and eliminate the influence of luck on people's relative positions. It then reflects over how to implement lower priority and discusses whether such an arrangement is vulnerable to the objections regarding harshness and shameful revelations.

[8] In Switzerland there is a degree of public travel insurance in health (Somer Kniestedt and Steffen 2006)

**Assessing Responsibility**

As a theory of distributive justice, luck egalitarianism is compatible with a wide range of views on what responsibility is and what it takes to be responsible for an outcome or an action (Knight 2006). Many luck egalitarians remain neutral about what the best theory of responsibility is (Arneson 1989, 68; Cohen 1989, 934, 1993, 28; Temkin 2011, 57). Some luck egalitarians have, however, offered specific views on how we should understand responsibility. Segall suggests that we should hold people responsible for the outcomes of actions we could reasonably have expected them to avoid (Segall 2010a, 19–24). Specifically, this means that we cannot reasonably expect people to avoid 'actions that agents generally have a vital interest in exercising, and/ or actions that society has a vital interest in having exercised' (Segall 2012, 330).[9] Roemer pursues the luck egalitarian ideal that '*society should indemnify people against poor outcomes that are the consequences of causes that are beyond their control, but not against outcomes that are the consequences of causes that are within their control, and therefore for which they are personally responsible'* (Roemer 1993, 147). Roemer suggests what he terms a political, rather than metaphysical view on responsibility. To assess responsibility society decides what it deems people to be responsible for in a given context. Building on this, people are divided into types, understood as 'a subset of the population, having approximately the same value on the factors' (Roemer 1993, 150, 1998, 7, 2001, 449, 2003, 261, 2012, 168). Within each type, people are equal in their circumstances understood as the degree to which they are subject to influences beyond their control. They differ however, in their effort their 'autonomously chosen action – within the individual's control – which, if expended in greater amounts, will increase the degree to which the individual acquires the objective' (Roemer 2003, 261). In assessing responsibility, Roemer suggests that we compare the expended effort of those within each type (Roemer 1998, 11). When comparing between types, we should compare the degree to which people

[9] For critiques of Segall see (Andersen 2012; Weinstock 2012)

differ from the median of their respective type (Roemer 1993, 151, 2012, 168, 1998, 18). According to Roemer, we have achieved our egalitarian goal if and when 'all those who exercised a comparable degree of responsibility are equal, regardless of their circumstances' (Roemer 1993, 149). Roemer's approach to responsibility has been extensively discussed in the literature.[10] A particular important concern is that countries vary a in what they would consider it reasonable to hold people responsible for. For this reason, we may want to evoke a different standard for sorting people into types. The discussions of responsibility, which follows, are inspired by Roemer's work, but does not profess to pinpoint how people in actual countries would deem other people responsible for. Instead, it follows the guiding principle of listing as circumstances, what most theories of responsibility would not consider people responsible for. Using this approach, let us see how an approach employing Roemer's conceptual framework of effort, type and circumstances can help us assess responsibility in the cases at hand.[11]

Consider first oral health, as illustrated through wisdom teeth and caries.[12] In terms of assessing responsibility, wisdom teeth illuminate that some specific disadvantages can as a whole be considered something which people are not responsible for. There is no need for an individual assessment nor for dividing people into types, as nothing indicates that the complexities and pain related to wisdom teeth can be avoided through individual effort. Caries, however, arises in a complex mix of behaviour and bad luck. The prevalence of caries relates to oral hygiene and food consumption (Moynihan and Petersen 2004; Sambunjak et al. 2011). However, natural factors influence prevalence and vulnerability. This includes Sjögren's disease (Mathews, Kurien, and Scofield 2008), diabetes (Sandberg et al. 2000), and cancers treated with chemotherapy (Michelet 2012). Socio-economic

[10] For important discussions see, (Hurley 2005; Hild and Voorhoeve 2004; Solow 1995)
[11] The article does argue that we should prefer Roemer's framework. A reader more sympathetic to Segall reasoning may think of what follows as a discussion of what is reasonable to hold people responsible for.
[12] For a lengthier discussion of caries, see (Albertsen 2015b)

factors also heavily influence the prevalence of caries (Chankanka et al. 2011). In general, the literature demonstrates the prevalence of social determinants in oral health (Petersen and Kwan 2011; Watt 2012).

In the liver case, we must also consider the social and natural factors affecting alcohol consumption and differential vulnerability. There is considerable evidence that social factors such as alcohol abuse in the family count as a risk factor (Rhee et al. 2003). Furthermore, poor social circumstances, unemployment and poverty are prevalent characteristics among those who abuse alcohol (Allen et al. 2017; Hoy 2017). Natural or genetic factors affect vulnerability to alcohol and the individual propensity to become addicted (Buscemi and Turchi 2011). Consider finally travel insurance. Here the picture is somewhat different. In assessing responsibility, it is important to note that people succumb to disease for many reasons while travelling (World Health Organization 2012). As we isolate this to those, who travel for fun and leisure we are unlikely to find the same patterns of social inequality and genetic vulnerability as the two areas just discussed. If what we assess is responsibility for the decision to travel (and to a lesser extent the responsibility to undertake risky activity while travelling), we have a quite different pattern than in the other areas.[13] The social profile of the travel insurance case highlights the source of an important objection to this way of assessing responsibility. If we deem people to be less responsible when their actions match the actions of those who are like them – could well-off people cite the fact that many well-off people travel as a reason to consider them less responsible for doing so? This is arguably not an implication of Roemer's approach. The reason for this is that there would have to be a certain strength to the effects of circumstance or social class on the choice to travel without insurance. One would suspect perhaps, that there is a difference between the distributions of the decision to travel and the choice to travel uninsured. Furthermore, and more importantly, there is arguably a difference between travelling

[13] One difference is that it is often the young who are uninsured (Farhoud 2018)

uninsured when you can hardly afford the insurance, and travelling uninsured when you can, which blurs this comparison.

This concern aside, the main obstacle for implementing a system based on Roemer's distinction between circumstance and effort is when sometimes we cannot observe past effort. This is true for caries in the context of oral health. We cannot know peoples' past behaviour in terms of oral hygiene and consumption of sugary food. Thus, we cannot directly assess their effort and compare that effort to others in the same type. For the transplant case, it is in one sense easier, as we can readily distinguish between those with an alcohol related need and those who need a new liver for different reasons. However, we cannot directly asses the past drinking behaviour of those in the former group. Travel insurance provides an example of a case, where we know people's past behaviour because we can assess whether they decided to travel and whether they took out insurance for potential diseases and costs associated with their vacation.

When we cannot assess people's past behaviours, we are faced with considerable difficulty. If we choose to consider as responsible for their health disadvantage everyone with caries and alcohol-related end-stage liver disease, we would not pay sufficient attention to the already presented factors potentially undermining responsibility. In light of this, the most workable system would be to would be to create a system of exceptions. Based on the epidemiological facts regarding what affects vulnerability and behaviour we can for each of the relevant health disadvantages create a list of exemptions. Within such a system, people with a given health disadvantage can be considered not responsible for this, if they can cite one or more responsibility undermining factor. There is a discussion to be had about what it would take for something to get on the list of exemptions. While a clear set of criteria cannot be presented here, Roemer's approach provides us with the thought that the list could consist of a number of different categories with different weight. If a person fits some of the criteria on this list, we can deem them not responsible and would have luck egalitarian grounds

for not giving the person lower priority. On the contrary, luck egalitarian compensation is required. For those who are deemed responsible, the next step would be an evaluation of whether any disadvantages in other spheres of life offset this.

**Offsetting unjust inequalities**

Following from the second, integrationist, element in the framework, the next step evaluates whether, among those deemed responsible for their health disadvantage, there are some who are unjustly worse off in others spheres of life. The focus will especially be on socio-economic factors, which may, even if they do not remove responsibility for the health disadvantage, count against giving lower priority. For those deemed responsible, and not unjustly worse off in other spheres, we would have luck egalitarian grounds for introducing lower priority. This section sets out ways to develop luck egalitarian policies, which ensures that the extent to which people's relative position reflect luck is neutralized or minimized. In doing so, it becomes clear that the second element in the framework involves a number of important commitments.

The first commitment is to assess whether those deemed responsible for their health disadvantage are in other spheres, worse off in other ways, which are unjust. Prime candidates to include as possible off-setting factors would be low income, little education or unemployment. Even when we cannot demonstrate that such factors undermine the responsibility for the person in questions' health disadvantage, the presence of such bad luck in the person's life, makes it likely that the best luck egalitarian policy is one, which does not give lower priority to them.

However, refraining from giving lower priority for adverse health outcomes cannot exhaust the luck egalitarian response to the identified factors. A commitment to neutralize the effect of luck on people's comparative positions must go beyond this. This second commitment is equally important and has broader ramifications. If we identify various ways in which individuals or social

groups are worse off than others through the factors just mentioned, we must actively address these factors. We have reasons pertaining to luck egalitarian distributive justice to do so. The luck egalitarian policy, properly understood, would also be committed to neutralize and eliminate such factors adversely affecting people's position. This is true independently of their adverse effect on people's responsibility for health. In terms of travel insurance, perhaps the most important element here would be to counter-balance lack of knowledge and misconceptions regarding travel insurance. It would not be good, from a luck egalitarian perspective, if people travelled uninsured under the false belief that they were already covered by their national insurance or national healthcare service. For the two other cases, equalizing access to education, jobs and resources are likely candidates for luck egalitarian policies.

The third commitment following from the luck-neutralizing is to examine whether there are aspects inside the healthcare system, which disproportionally lets people's social circumstance affect people's position. This is clearly relevant in the organ allocation case. Factors influencing the allocation process should not reflect differential luck. In a recent discussion of this, Rosoff points out that seemingly clinical and well-justified criteria for organ allocation can deepen existing inequalities, by benefitting those of a specific class or race (Rosoff 2017, 178). Furthermore, some criteria employed in the system can themselves be a matter of luck. Thus, we could very well have luck egalitarian grounds for opposing the significant role played by geography in the current US system (OPTN 2012).

Summarizing this section and the one, which preceded it, we may describe the role of luck as a filtering mechanism affecting both decisions on whether to give lower priority and broader societal policies. Social factors people are not responsible for provides reasons to not give lower priority, both when they mitigate responsibility for the health disadvantage and when they unjustly disadvantage people. Some factors, such as poverty, are both unjust for how they affect health and

for how they affect people's overall advantage. Furthermore, the luck egalitarian commitment to mitigate the influence from luck provides us with reasons to eliminate these factors and/or mitigate their impact on people's relative positions.

**Lower priority in light of non-justice based considerations**

The above two sections fleshed out how we can assess whether people are responsible, and raised the issue of how we should in an integrationist fashion identify factors which unjustly disadvantaged them. These factors can then both provide us with a reason for not giving them lower priority and furthermore give us luck egalitarian reasons to counteract and neutralize such unjust disadvantage. The above framework maintains, that for those where the process above did not provide us with reasons not to give them lower priority we would have a pro tanto reason to do so. Whether we, in the end, give lower priority or not depends on whether there are reasons beyond distributive justice to refrain from doing so. In the pluralistic spirit of the framework employed here, this section addresses this. It considers whether we can introduce measures of lower priority without being too harsh or too intrusive. This discussion over permissible ways for introducing lower priority is conducted by looking at each of the three areas under analysis. It is important to stress that decisions of priority setting should be made through overall principles ensuring that equal cases are treated alike.

Consider first oral health. Denying treatment is not the only option. It is not even a very plausible one for the pluralist luck egalitarian approach. Why should we maintain that those responsible for their bad oral health should go untreated? Why not introduce a system that lets them decide for themselves, whether they want to be treated at their own expense. A system of co-payment has two additional benefits. It provides another instrument to mitigate social inequalities in health by introducing some form of public reimbursement for some social-disadvantaged groups, and it allows

for partial responsibility, where those who can cite only a few or minor mitigating circumstances pay a fraction of the full amount paid by those without such.

For liver allocation, it has been suggested that luck egalitarianism would recommend giving lower priority to all patients with alcohol-related end stage liver disease (Albertsen 2016b; Arneson 2004, 20; Knight 2013, 159; Segall 2007a, 177, 2010a, 29). The system of exemptions stresses the need for an individual assessment, something not always acknowledged in the literature. What kind of lower priority should be introduced in the liver allocation case? There is, of course, no need to deny treatment, but the solution of co-payments makes little sense here.[14] The shortage of organs is the major obstacle for performing transplants. The most plausible solution is that those deemed responsible receive lower priority in the allocation of livers. In doing so, the pluralist luck egalitarian framework would introduce responsibility alongside other criteria such as urgency and capacity to benefit. How should we conduct such weighting of values? Lexical ranking with responsibility as the first principle is unsatisfying. This would mean that a person deemed responsible would have to wait until every non-responsible person is treated, no matter how sick or unable to benefit. On the other hand, introducing responsibility merely as a tie-breaker offers too little. The idea of allowing responsibility a role only when people are equally disadvantaged and equally capable of benefitting would mean that responsibility is relegated to an unimportant afterthought. A third suggestion would seek to correct for both these issues. If we understand capacity to benefit as a threshold one has to be above to be considered for transplantation, and measure urgency of need using the MELD score. This score describes the likelihood that one will die within 90 days, then we can rank each patient on the scale from 1-40 which MELD covers (Martin et al. 2007). If those deemed responsible are subtracted two points on this score, we significantly reduce their chance of receiving

[14] For a broader discussion of health taxes, see (Albertsen 2016a)

a transplant but ensures that those who are treated can benefit and that those who receive lower priority are not disproportionally needier than those advantaged by the policy.

Consider then travel insurance. Two different luck egalitarian approaches seem to be worth discussing as responsibility-sensitive alternatives to current schemes. One holds that the public should cover the costs associated with diseases, which an individual is not responsible for, acquired while traveling. In this case, only conditions for which the individual is responsible can be discussed, and for these perhaps they should be asked to shoulder some of the associated cost. From one perspective, this is a luck egalitarian adjustment of current practices, as it filters out diseases for which the individual is not responsible, concerning itself only with those for which the person is responsible. The adjustment adheres to the principle that a disease covered under a luck egalitarian health system at home is also covered abroad. While there is, from a luck egalitarian perspective, something to be said for such an arrangement, it does allow for problematic cost displacement. While costs covered under this scheme are, by hypothesis, associated with an illness for which the person is not responsible, they could be considered responsible for the travelling itself. If the decision to travel adds additional costs to the healthcare system when treatment and transport is covered, there may be luck egalitarian reasons to introduce a scheme in which people who are considered responsible for the decision to travel will be held (partly or fully) responsible for this decision and the costs associated with illness on their travels.

*Harshness*

Are the institutional measures proposed above too harsh on those who are worse off as a result of their own exercising of responsibility? In the oral health case, the 'harshness' introduced through the proposed co-payments bears little resemblance to the kind of harshness envisioned in the general debates over luck egalitarianism. The flexibility of the luck egalitarian approach offsets this concern

in the case of caries. In the liver allocation scheme the responsible person's claim on life-prolonging transplantation is weakened. Still, this case does not reflect badly on luck egalitarianism, despite the severity of the outcome. It is the organ scarcity rather than the luck egalitarian policy, which causes harshness. Any distributive principle would result in not treating someone. Would this mean that any distributive principle is too harsh in this context? It is unlikely that those putting forward the harshness objection would believe so. Travel insurance delivers an interestingly different case. While, as already stated, refusing treatment need not be the luck egalitarian method of giving lower priority, even co-payment might be considered harsh in a case where we may expect the costs to be high. On the assumptions that travel insurance is available and affordable when viewed in relation to the cost of travelling for leisure, it is unlikely the case of travel insurance adequately reflects the concern that the harshness objection is meant to convey. While one could see it as the traditional harshness objection with further expenses added, there are remarkable differences between the cases discussed here and those traditionally employed in the literature. Firstly, the people travelling may be better off than others, and the insurance is thus within their economic means. The type of activity may also matter for our assessment. Injuring yourself while swimming with dolphins may simply give rise to different intuitions than succumbing to cancer after a long life as a smoker. The inability of luck egalitarianism to come to the aid of well-off people who forgo readily available and affordable insurance are unlikely to count against it.

*Shameful revelations*

Consider shameful revelations. While there is no clear-cut way to establish whether assessments of responsibility would be shameful or constitute a lack of respect, two remarks can be made in the context of oral health. Firstly, there is an inverse relationship between precision in the acquired information and the level of intrusiveness. If we rely on rough estimates and readily available

information, then institutions do not risk engaging in shameful revelations but do run the risk of getting the assessment of responsibility wrong. Furthermore, much of the information on the list of exemptions would already be in either the healthcare system (co-existing diseases) or in the welfare system (if people receive public welfare benefits).

Regarding livers, two things should be noted regarding shameful revelations. One is that the topics addressed in assessing responsibility, are indeed very personal. This speaks for this to be a weighty concern. On the other hand, one should perhaps also take into account that very personal questions are already part of the transplantation process. Questions that ensure that a person can participate as a suitable transplant recipient are quite personal (Levenson and Olbrisch 2011). If we are allowed to ask deeply personal questions for reasons of efficiency, should we also be allowed to ask them for reasons of fairness? Assessing the responsibility for travelling while uninsured seems much less demeaning, if at all, than the situations sometimes depicted by the critique. Shameful revelations seem to have little relevance here.

Taking the three cases together we msut say that shameful revelations is a relevant concern for at least the liver case and perhaps also oral health. There are three important observations which counter this in the context of the framework under discussion. The first is the already noted trade-off between intrusiveness and precision. Often it will be the case that the more confident we want to be about the correctness of our assessment of responsibility, the more information we need to collect. Secondly, this is also true about information needed to provide health care based on need or efficiency. The third remark to make regarding shameful revelations pertains to the pluralism of the applied framework. If the assessment of responsibility becomes too degrading, intrusive or problematic, we have pluralistic reasons for not introducing responsibility-sensitive institutions.

**Insights for policy**

While responsibility-sensitive policies are often firmly associated with deservingness and right-wing ideologies, the above shows that applying a responsibility-sensitive theory of justice to health ends up in a somewhat different place policy-wise.

Instead of policies which gives lower priority to specific groups, or which deprioritizes whole groups of patients, luck egalitarianism is much better understood as requiring individual assessments. Whereas the focus is often on holding people responsible and assess responsibility, the above discussion also shows how luck egalitarianisms commitment to mitigate the influence of luck on people's lives can be very important for policies. It provides a justice based reason to eliminate social determinants in health, but also for broader policies of redistribution and poverty-mitigation.

The analyzis also shows, that a luck egalitarian responsible-sensitive approach to oral health would differ from existing practices in most countries. It would include that treatment for some forms of poor oral health, such as those associated with wisdom teeth, should be free of charge. Luck egalitarians should support co-payment, but only for those where an individual assessment concludes that they are indeed responsible for their own poor oral health. In most countries, such an approach would likely increase rather than decrease the public coverage of oral health disadvantage. Whereas for the other areas analysed, there might be more room for personal-responsibility than current policies (though this depends on a number of empirical facts not fully assessed here), the policies are little like those depicted by critiques of luck egalitarianism and should be implemented alongside distributive measures little like those recommended by the political right.

**Conclusion**

A pluralistic luck egalitarian theory which focusses on health, is integrationist and allows for a wide range of ways in which we can hold people responsible, proves a much different beast, than the

current literature allows for. Rather than a harsh, intrusive and generally implausible theory in the context of health and healthcare, it is a flexible theory. A theory readily able to address important social and natural circumstances differentially affecting people's health. And which, properly construed, is much less vulnerable prominent critiques regarding harshness and shameful revelations. Furthermore, the anti-luck sentiment of luck egalitarianism must be taken serious and its wide ramifications for redistributive policies acknowledged.

**Biography**

Andreas Albertsen's research interests are in political theory, distributive justice and medical ethics. He has published in Politics, Philosophy and Economic; Political Research Quarterly; Bioethics; Ethical Theory and Moral Practice; Journal of Medical Ethics; and Journal of Medicine and Philosophy.

**Acknowledgements**

This paper came into existence in a rather complicated manner. Some elements originate from a long discarded paper on equal opportunity for health. Other elements originate from discussions following talks I have given on luck egalitarianism in health. For these reasons a number of people have helped me writing this paper before it was really this paper. I would like to acknowledge participants at the following events for having contributed to this paper with insightful comments: a guest lecture at the University of Copenhagen, invited by Foreningen Suveræn, May 2015; the Society for Applied Philosophy Conference in Edinburgh, July 2015; Equality of Opportunity Conference Duke Law School, North Carolina, May 2016; Higher Seminar, Department of Philosophy, Goteborg, June 2016. I am grateful for comments received from: Matthew Adler, Richard Arneson, David V. Axelsen, Gabriele Badano, Bengt Brülde, Pedro Rosa Dias, John Eriksson, Nir Eyal, Francisci Ferreira, Rasmus Sommer Hansen, Sofia Jeppsson, Simon Lauman Jørgensen, Carl Knight, Søren Flinch Midtgaard, Lasse Nielsen, Ben Sachs, Shlomi Segall, Sean Sinclair, Jens Damgaard Thaysen, Frej K. Thomsen, Alain Trannoy, Alex Voorhoeve, Roy Van der Welde and three anonymous reviewers from Political Research Quarterly.

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