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ETHICAL ISSUES IN GOVERNMENTAL EFFORTS TO PROMOTE HEALTH

By

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ETHICAL ISSUES IN GOVERNMENTAL EFFORTS TO PROMOTE HEALTH

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What should be the government's role in promoting the kinds of personal behavior that lead to long life and good health? Smoking, over-eating, and lack of exercise increase one's chances of suffering illness later in life, as do many other habits. "The greatest current potential for improving the health of the American people is to be found in what they do and don't do for themselves," 1/ but the public has shown little spontaneous interest in reforming. If the government uses the means at its disposal to remedy the situation, it may be faced with problems of an ethical nature. Education, exhortation, and other mild measures may not prove effective in inducing self-destructive individuals to change their behavior. Attention might turn instead to other means, which although possibly more effective, might also be intrusive, coercive, manipulative, or otherwise distasteful to those to whom they are applied. In the present essay, I seek to identify the moral principles that provide a reasoned judgment on whether these stronger methods should justifiably be used, and, if so, what limits ought to be observed.

The present inquiry occurs at a time when an expansion of government efforts to reform unhealthful habits seems imminent.2,3/ Behind this shift is a host of factors. One is the pattern of disease: the chronic illnesses and accidental injuries to which living habits contribute constitute an increasing share of ill health. If this were not enough to increase interest in preventive

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1/ Fuchs (26), pp. 54-55. Note: Citations consist of author's name and the number of the entry in the bibliography that follows this text.

2/ U.S. DHEW (66), p. 100.

3/ Lalonde (39).

behavioral change, it would be abetted by the current wave of "therapeutic nihilism," which, in its doubt over the efficacy and even safety of medical interventions after the onset of illness, is more friendly to health efforts that begin and end at home.

That reform of unhealthful ways of living should be undertaken by the government, rather than by private individuals or associations, is perhaps a partial result of the emergence of government as a major health care provider. Reforms for personal health may be a cost effective way to "deliver" health, especially if better change-inducing techniques are developed.4/ This feature may make prevention especially attractive if the current cost control problems persist.

Pressure on the government for strong measures to change unhealthful habits might come from those who live prudently. Federal support of curative medical care services gives all taxpayers a stake in keeping health costs down, and the cautious and moderate may come to view self-destructive habits as financial aggression against them. This attitude, and the demands for government intervention that follow from it, could intensify if a national health insurance plan or a national health service were enacted.

It is, then, time to reflect on the kinds of interventions the public should want and should accept. Certain interventions might be justified by some goals and not by others. The goals, therefore, must be identified and examined.

Although some of the behavioral changes discussed in this paper are unpleasant and unwelcome, most

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4/ Despite dispute over the effectiveness of many health promotion measures, efficient techniques may be developed in step with the progress of behavioral medicine generally. See Ubell (65) and Pomerleau (54).

techniques actually used are not, and there is therefore little need to justify them. Also, each policy goal is discussed in isolation from the others. It is probable, however, that any actual government program in this area would be expected to serve several purposes.

Three possible goals of government intervention to encourage healthful behavior are discussed in this paper. The first goal is health, valued for its own sake. The second is that of fair distribution of the burdens caused by illness. Those who become ill because of unhealthful habits may require the financial support of the more prudent, as well as the sharing of what may be scarce medical facilities, and government intervention might be seen as accomplishing distributive justice. And third, the government might be motivated to change living habits in hopes of improving or, at least, maintaining the general welfare, for the health of the population does affect the economy, allocation of resources, and national security.

Health, fairness, and general welfare are uncontroversial goals. Moral scrutiny is required when they are pursued by methods that threaten other highly regarded values. Clearly, some limitations of freedom are justified; and, likewise, goals such as health and general welfare cannot justify any and all limitations of freedom.

Health as a Goal in Itself

Present interest in changing unhealthful habits stems largely from concern with the fate of those who live dangerously. Few would quarrel with this goal, and there are several steps that might be justified by its pursuit. The government could make the facts concerning the effects of unhealthful living habits known to those who practice them, and could sponsor research to discover more of these facts. The chief cause for concern over such efforts might be that the government would commence its urgings before the

facts in question had been firmly established, thus lending government authority to the adoption of living habits that might be useless or perhaps detrimental to good health.

Most debate, however, would be occasioned by a decision to use stronger methods. A "fat" tax would be a case in point: the government might require its citizens to be weighed, and a tax would be imposed on the overweight. The revenues generated by such a tax might be held in trust, to be refunded with interest if and when the taxpayer brought his weight down to a more healthful level.5/ This would be a bond imposed by the government on overweight citizens, and thus is coercive.

The two signal properties of this policy would be, first, that it aimed at the improvement of the welfare of the obese taxpayer; and, second, that it was presumably unwelcome to him. The first property might be called "beneficence," which is generally considered a virtue. But in the presence of the second property, it becomes paternalism, and its status as a virtue is questionable. "Paternalism" is defined in this paper as a measure imposed on a person for his or her own good that he or she would not want if asked.6,7/

5/ While the hypothetical fat tax is an unlikely and extreme form of intervention, it shares important features with others that have been proposed.

6/ "Coercive beneficence" is not a fully correct definition of paternalism; but I will not attempt to give adequate definition here. See Gert and Culver (28). The term itself is unnecessarily sex-linked; "parentalism" carries the same meaning without this feature. However, "paternalism" is a standard term in philosophical writing, and a change from it invites confusion.

7/ For detailed discussions of paternalism in the abstract, see Feinberg (24), Dworkin (22), and Bayles (4).

Our question, then, is whether paternalistic policies such as a "fat tax" would be morally justified and, particularly, whether such policies could be justified on paternalistic grounds alone. Defenders of the "fat tax" might give other reasons for it, such as the desirability of raising revenue from individuals who are likely to incur large medical expenses. But let us imagine that the funds would be withheld solely to exert pressure on the taxpayer to lose weight. Likewise, let us imagine that there is no shortage of medical facilities or funds to maintain them, and no desire on the part of the slim to be rid of the fat; justification of the tax policy would stem solely from a desire to benefit obese taxpayers.

It is not certain that any good would issue from this program, but if any did, it would be the taxpayer's health. Let us suppose that the program works in taxpayer Smith's case as it was intended to, and that as a result Smith has returned to a normal weight and has improved his prospects for a long life span. Is there anything on the debit side that might outweigh the gain in longevity?

There are several untoward aspects of this type of policy. Although Smith gets all his money back, other coercive programs might impose a cure which would be unpleasant enough to offset the benefits to be gained. There are reasons to resist giving the government any more authority to impose programs like this than are really necessary, for they may be incompetently administered; worse still, at some point, the power thus invested in the government might be used for the wrong purposes--uses less benign than the pursuit of health. Last, and most generally, the more one is protected from the consequences of one's own mistakes, the less likely it is that one will learn from them. These considerations are so general that it is difficult to assign any particular weight to them in judging a specific program, but collectively they provide a rationale for proceeding

with caution in lending support to paternalistic programs.

There is, however, a specific loss imposed on Smith by this protective tax, and that is the loss of the privilege of self-direction. Generally speaking, the signal defect of paternalism is arrogation of the locus of decision-making, something much prized in itself. This loss is definitionally inextricable from paternalism since it always involves a loss to the subject along with any benefits it might bestow.

Paternalism, however, is not always a bad bargain for those subjected to it. Even libertarians are unlikely to oppose paternalistic care of young children. There is general acceptance of public protection for moderately and severely retarded persons, even at the cost of some of their civil liberties. The rationale for accepting paternalistic regulation of these and other vulnerable populations is clear: without protection they are more likely to suffer harm. In addition, their capacity for self-direction is limited; they have less autonomy to lose when direction is imposed on them by others or by the state.

If these two factors--need for protection and lack of capacity for self-direction--justify paternalism for children and the severely retarded, perhaps they do the same for other populations when these factors are present. On occasion, ordinary adults like Smith may exhibit these characteristics. In deciding whether coercive measures to encourage healthful living habits can be justified, one must assess what might be called the "voluntary" quality of the decisions involved in maintaining those habits.

The Voluntary Element in Making Decisions

The best decisions--those that realize the interests of the actor and of those whom he or she cares about--

involve success in three respects. First, the actor will have knowledge of all of the principal possible consequences of the acts open to him; second, he will be able to estimate the probabilities of these actually coming about; and, third, he will assign values to the various possible consequences. In the simplest case, the values are multiplied by the probabilities for each consequence of each action, and these are added up. The action with the highest index is the rational choice. For example, Smith may be certain of a small pleasure if he eats a bonbon, but there is a small increase in the probability that he will suffer shortened life span. If he refrains from eating the bonbon, he loses the pleasure of the food, but also does not put himself in further jeopardy of early death. Whether it will be rational to eat the bonbon depends on how much he likes bonbons, how much he is likely to loathe early death, and how much eating this bonbon will shorten his life span. If he is subject to a fat tax, then there may be a financial consideration as well.

A decision with consequences for an individual's health, such as Smith's deliberations before eating bonbons, may fall short of this ideal in any or all of these respects. Smith, for example, may be ignorant of some of the consequences of eating sweets. His ignorance detracts from his ability to make a decision that takes into account his other interests. In this instance, there is cause for guidance.

It is true that his ignorance in these matters might be matched by ignorance of other relevant facts on the part of those who would intervene, with the result that the intervention would be as destructive as Smith's own choice might have been. Indeed, the presumption that the individual usually knows best is part of the standard case against paternalism. But poor decisions made in ignorance are not entirely beyond the scope of the paternalist. There are, after all, right and wrong answers to the questions of fact involved, and others

may have expertise grounded in scientific information.8/

Paternalistic intervention based on the justification that the decisions to be affected suffer from inappropriate assessment of the consequences are on shakier ground. Although we, as individuals, often are critical of the importance others place on certain events and things, we also are hesitant to claim any special authority or expertise in such matters. The pluralist ethic to which, for better or for worse, most of us subscribe, has as its central tenet the proposition that there are multiple distinct but equally "valid" conceptions of the good and of the good life. Intervening paternalistically in another's health-related decisions on the ground that the person in question assigned false importance or value to some of the possible outcomes goes against the grain of this ethic.

There is but a thin line between paternalism--forcing or pressuring a person to act in his own best interests--and the imposition of our own values. If a person's ability to make effective decisions is compromised in some way, so that he is disabled in his effort to pursue his own ends, we may have a presumptive ground for intervening on his behalf. However, disability is no ground at all for seizing this opportunity to force or pressure him into adopting ends which we happen to favor personally but which the target of our intervention would consider foreign.

8/ This is not to say that ignorance justifies any and all interventions. Since all human actions fall short of omniscience, this would make all behavior fair game for the paternalist. Instead, a reasonable human standard of knowledge must be used, and the agent's ignorance must be considered along with the seriousness of the impending harms. Then this must be balanced against the dangers of allowing others the power to intervene when they think they know best.

It is possible that we can forswear the imposition of our personal values and at the same time insist that another's decisions are defective precisely in the values they assign to various possible outcomes. We may legitimately do so only if we restrict our criticisms to a few specific defects. First, it is sometimes clear that the person making decisions injurious to his own interests is pursuing ends that have been imposed upon him from without or fostered from within by some pathological condition. Commercial or social pressure, if acute, may instill in Smith the desire to consume certain substances whose pleasures he would have considered trifling if left to his own patterns of valuing. Similarly, if Smith values certain experiences as the result of an unfortunate psychological compulsion or addiction, then there is no virtue in standing back and pretending that Smith's actions are voluntary and consistent with his long-term goals.9/ Second, some outcomes are valued not because they are intrinsically valuable, but because they are believed by the agent to lead to other valued experiences. One drinker, for example, might value intoxication as an experience itself; another might value it because he believes it will enhance social acceptance. But an agent may be mistaken in believing that the outcome he pursues does in fact lead to outcomes which he values for themselves. For example, the drinker's "valuing" of intoxication may be due to simple ignorance of the facts.

9/ Again, this is not to say that paternalistic intervention is justified every time a person assigns inordinately high value to a given outcome as the result of social or psychological compulsion. As with ignorance, the defect has significance only in its impact on the voluntary nature of the act and merely creates a presumptive case for paternalistic intervention. Whether the intervention is justified depends on a host of other factors as well, such as the wisdom of the intervening authorities and the possibilities for abuse.

This last mode of justifying paternalistic intervention--finding fault with individual goals and values because of factual mistakes--is particularly relevant to health-related behavior. Health is itself a means to almost all ends. It might be argued that no one would rationally choose to compromise his health. No matter how eccentric a person's values and tastes are, no matter what kinds of activities are pleasurable to him, it is impossible to engage in them unless alive. Unless he believes in an afterlife, on this view, the rational man must rate death as an incomparable calamity, for if it occurs it means the loss of everything else that is valued. Thus, the argument concludes, we have logical grounds for doubting the voluntary nature of any act that would threaten health, and there exists a case for intervention that avoids questioning the agent's values.

This argument, or something like it, may lie behind the willingness of some to endorse paternalistic regulation of the lives of apparently competent adults. The conclusions, however, often do not follow from the premises. For example, time factors are ignored: an act performed at age 25 that risks death at age 50 does not threaten every valued activity. It simply threatens the continuation of those activities past the age of 50. The argument also overlooks an interplay between the possible courses of action: if every action that carries some risk of death or crippling illness is avoided, the enjoyment of life decreases. This makes continued life less likely to be worth the price of giving up favorite unhealthful habits. Although it may be true that death would deny one of all chances for valued experiences, the experiences that make up some people's lives have little value. The less valuable life may be to a person, the more rational it is to engage in exciting or pleasurable risky activities, even though the result may be premature death or morbidity. However, though the rationality of behavior that leads to chronic illness or accidental injury cannot be ruled out *a priori*, it is often

not fully under the control of the individual. Involuntariness must be shown if paternalistic intervention is to be justified, and this can best be determined on a case-by-case basis.

The difficulty of formulating a government reform policy is that a given intervention is most likely to be tailored to practices and habits than to people. Although we may some day have a fat tax to combat obesity, it would be surprising indeed to find one that imposed charges only on those whose obesity was due to involuntary factors. It would be difficult to reach agreement on what constituted diminished voluntariness, harder still to measure it, and administratively impractical to make the necessary exceptions and adjustments.10/

Each attempt to justify paternalistic practices faces the need to balance off several concerns. Like Ulysses approaching the sirens, the rational man may wish to be protected from the injuries he may inflict upon himself in times of impaired decision-making ability. But licensing others to impose well-being upon him over his express wishes at a later time runs the risks mentioned above--of insensitivity to his particular needs, of misguided attempts to impose alien interests and values, of incompetent attempts at assistance, and even of malevolent exploitation of the power he has relinquished. License to protect a person from himself should be reserved for instances when fundamental and important needs must be protected. Also,

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10/ One man (Smith) may overeat because of an oral fixation over which he has no control, or as a conditioned response to enticing television advertisements. Another (Jones) may have thought matters through and decided in favor of a shorter though gastronomically happier life (see Claiborne, 16). Smith's diminished voluntariness lends support to paternalist intervention; but to pressure Jones into changing so that he will live longer would clearly be an imposition of values. If a "fat tax" were considered, we

the discretion of the intervening party in devising protective measures should be limited.11/

Methods Should Fit the Need

Even if we could be assured that government were competent and well-intentioned when it exercised its authority, the intervention ought to fit the need. The nature of the intervention is dictated, in part, by the cause of the inability to make decisions. For example, if Smith's overeating is the result of ignorance about the causes of obesity, the proper paternalistic remedy is information, not penalties

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face a choice: do we owe it to those like Jones not to enforce alien values more than we owe it to those like Smith to protect him from self-destruction? The epicure's general right to answer to his own values, a presumptive right conferred by the pluralist ethic spoken of above, might count for more than the need of Smith to have health imposed upon him, since the first violates a right and the second merely confers an (unrequested!) benefit. But the situation is more complex than this. Smith's life is at stake, and this may be of greater concern (everything else being equal) than the epicure's pleasures. Then, too, the epicure is receiving a compensating benefit in the form of longer life, even if this is not an exchange he welcomes. And there may be many more people like Smith than like Jones. On the other hand, the positive causal link between tax and health for either man is indirect and tenuous, while the negative relation between tax and gastronomic pleasure is relatively more substantial. For a fuller discussion of this type of decision-making, see Bayles (4).

11/ The "social insurance" rationale for certain kinds of paternalistic measures is sketched by Dworkin (22) and by Murphy (47).

for being overweight. Similarly, if his overeating could be traced to irresistible commercial or social pressure and influence, intervention might more properly be directed at these factors. Indeed, paternalism might call for less deprivation and coercion rather than more.

Another reason to shift the focus of intervention from the individual with poor health habits to other conditions in his environment, which may be responsible for his plight, is that the involuntary nature of his behavior may make paternalistic reform efforts ineffective. To the extent that the behavior is not under the control of the individual, we cannot expect the kind of financial threat involved in a "fat tax" to exert much influence. Paradoxically, the very conditions under which paternalistic intervention seems most justified are those in which many of the methods available are least likely to succeed. The result of intervention under these circumstances may be a failure to change the life-threatening behavior, and a needless and inexcusable addition to the individual's woes through the unpleasantness of the intervention itself.

Problems in Formulating Policy

Generally speaking, the sorts of paternalistic interventions in our lives that are most likely to be justified--indeed, which we might even welcome--are those imposed by a benevolent and competent authority acting to assist us in achieving our own ends on occasions in which we are not competent to do so ourselves.

There is, however, a political constraint on paternalistic intervention into private life. In a democratic society, it is not enough that the government be competent to recognize involuntary self-destructive behavior and to guide it in health promoting directions. The government must be perceived as such by the public, for otherwise it will not be invested through the

political process with the proper authority to take it upon itself to bring about these changes. There is reason to doubt the actual competence of the government in these matters, especially if the numerous limits and distinctions that seem to be morally required are to be observed. That the government is trusted by the public in this regard is still more doubtful.

Although the aim of legitimate paternalism is assisting the individual in the pursuit of his or her own ends, there is considerable danger in imposing the moral beliefs of one person on another. One way of doing this would be to impose health and safety upon an individual as goals when his own interests lie elsewhere. David Mechanic has pointed out that the imposition of morals in the guise of paternalism can occur in another way as well.12/ Those people who wish to reform the unhealthful habits of others give as their stated motive for changing certain habits the damage caused by the habits upon the individual's health. But their real reason--conscious or otherwise--might be simple moral revulsion to the habits themselves. Skiing produces injuries as surely as sloth produces heart disease; and the decision to postpone childbearing until the thirties increases susceptibility to certain cancers in women.13/ The fact that these practices are not ordinarily pointed to in this regard provides no argument as such against paternalistic policies. But those who favor pressuring sedentary individuals to engage in exercise on paternalistic grounds might ask themselves if they also favor pressure on individuals whose habits are equally unhealthy but not otherwise despised. If there is less zeal for paternalistic intervention in these latter cases, it may be a signal for reexamination of motivation.

Two final points on paternalism in preventive health care are less critical but, nevertheless, worth

12/ Personal communication.
13/ Medawar (42).

mentioning. First, most actions falling under the rubric of "health promotion," and even "lifestyle reform," are quite innocuous. It will not matter if the motivation for these actions is paternalistic, nor whether the behaviors they seek to affect are voluntary. Second, although I have devoted much attention to the paternalistic case for reform, it is not one often encountered in the professional literature. Certainly few wear the "paternalist" label proudly.14/ A more common argument for inducing change is that a person who wrecks his own health imposes unfair burdens on others.

Fair Distribution of Burdens

The most frequently encountered argument for interfering with unhealthful ways of living is that others are made to suffer unfairly. The person who contributes to his own heart disease or cancer through obesity or smoking hurts not only himself, but also those who must share available medical resources and pay his medical bills. What, exactly, is the cause for interference in private conduct that is cited by those complaining of the financial burdens placed on society by the self-destructive? It is not simply the burden of caring and paying for care of these people when they become sick. Many classes of people besides the self-destructive impose substantial costs on the public. For example, diabetics and others

14/ What I am calling paternalism is usually expressed as simple concern for the health of the self-destructive. The classical terms for this concern are "charity" and "benevolence," but these become paternalistic when the measures they motivate are coercive or punitive. Suggestions of exerting pressure on the self-destructive for their own sake are not uncommon in the literature, and it is this motivation that I have addressed in this section.

with hereditary predisposition to contract disease incur heavy expenses, and these are routinely paid by others. Why are these costs not resisted as well?

One answer is that there is resistance to these other costs, which partly explains why we do not have a national health insurance system. But even those willing to pay for the costs of caring for diabetics or the medical expenses of the poor may bridle when faced with the needs of those who have compromised their own health. Is there a principled rationale for resisting the latter kinds of costs while accepting the former? One possible reason to distinguish the costs of the person with an inherited disease from those of the person with a lifestyle-induced disease is simply that one can be prevented and the other cannot.

But this is not the argument we seek. The medical costs incurred by diseases caused by unhealthful habits may be preventable, if our behavior methods are effective. But this fact shows only that there is a utilitarian opportunity for reducing costs and saving health care dollars. It does not show that this opportunity makes it fair to burden those with unhealthful habits with government intrusion.

Fault and Responsibility

If intrusion is to be justified on the grounds that unhealthful living imposes unfair financial burdens on others, then something must be added to the argument. That extra element, it seems, is fault: instead of the avoidability of the illnesses and their expenses, we point to the responsibility for them, which we may believe to fall upon those who contract them. This responsibility makes it unfair to force others to pay the bills and makes it fair for others to take steps to prevent the behaviors that might lead to the illness, even at the cost of some of the responsible person's privacy and liberty. The notions of fault and responsibility play a key role in our thinking about justice and fair distribution of burdens. They may be used to fashion an argument in favor of coercive

health promotion methods, and this might ultimately prove persuasive. Since the substance of the argument is familiar, I will refrain from formulating it and focus instead on the problems that this approach engenders.

First, the arguments depend on the premise that the person who engages in an unhealthful lifestyle is responsible for the costs of caring for the illness that it produces. The notion of responsibility was brought into the argument in hopes of contrasting diseases related to style of life from other diseases, and involves the notions of choice and voluntariness. But what if it should turn out that a person's smoking habit were the result of forces beyond the smoker's control? If the habit is involuntary, so is the resulting illness; and the smoker in this instance is no more to be held liable for imposing the costs of treatment than would, say, a diabetic. Furthermore, many such persons will not be in a position to respond to disincentives and coercion; these measures can only reduce the fairness of the distribution of burdens.

Second, even if the behavior leading to illness is wholly voluntary, intervention by the state is not necessarily justified. The only parties with the right to reform lifestyles on these grounds are those who are actually burdened by the costs involved, such as members of an insurance plan.

National Health Insurance

The above objection may lose force should there be a national health insurance program in which membership is mandatory. But this development would raise a third possible objection, for it presents another ground for disputing the responsibility of the self-destructive individual for the costs of his medical care. To state this objection, two classes of acts must be distinguished: the acts constituting the habits that cause the diseases and create the need

for care; and, the acts imposing financial shackles on an unwilling public. Unless the acts in the first group are voluntary, the argument for imposing behavior change does not get off the ground. Even if they are, those in the second class might not be. The destructive acts have effects on others only because others are in a financial relationship with the individual, which causes the costs of medical care to be distributed among them. If the financial arrangement is mandatory, then the individual may not have chosen that his acts should have these effects on others. It seems difficult to assign responsibility to this individual for the distribution of financial burdens. He or she may be responsible for getting sick, but not for having the sickness affect others adversely.

This objection has inherent limitations. It applies only to those brought into a mandatory insurance scheme against their wishes. Further, the burden under such a plan is not imposed until the person who has made himself sick requests treatment and presents the bill to the public. Only if treatment is mandatory and financing of care is wholly public can the imposition of burdens be said to be involuntary.

In any case, there are certain adjustments a national health insurance plan might make in answer to this objection. Two such changes are obvious: the plan could be voluntary, rather than mandatory, and the public could simply accept the burdens imposed by unhealthful habits and refrain from attempts to modify them. The first of these may be impractical for economic reasons, 15/ and the second ignores the problem for which it is supposed to be a solution.

There is, however, a response that would seem to have more chance of success: devising a method by which those with unhealthful habits could pay their own way. Users of cigarettes and alcohol could be made to pay an excise tax, the proceeds of which would cover the costs of treatment for lung

15/ In part because the plan would fill up with those in greatest need, escalating costs.

cancer and other resulting illnesses. Unfortunately, these costs would also be paid by users who are not abusers: those who drink only socially. Only those contracting the illnesses involved could be charged, but it would be difficult to distinguish those whose illness resulted from immoderate habits from those whose illness was due to genetic or environmental causes. The best solution might be to identify those taking risks (by tests for heavy smoking, alcohol abuse, or dangerous inactivity), and charge higher health insurance premiums accordingly. This method could be used only if tests for these behaviors were developed that were not intrusive and that could be administered easily.16/ The point would be to have those choosing self-destructive living habits assume the "true" costs of their habits themselves, if the costs could be determined. The cost to be computed, of course, is that of the behavior-produced illness, less the costs that the risk-taker would otherwise have incurred in his old age.

This policy has its good and bad points. Chief among the favorable ones is that it allows a maximum retention of liberty in a situation in which liberty carries a price. Under such a policy, those who wished to continue their self-destructive ways without pressure or coercion to change could do so, provided that they were willing to absorb the costs of their practices themselves. Should they not wish to shoulder these costs, they could submit to the efforts of the government to induce changes in their behavior. If the rationale for coercive or intrusive lifestyle reform measures is the burden the unhealthy lifestyles impose on others, this option seems to meet its goals; and it does so in a way that does not require loss of liberty and immunity from intrusions. Indeed, committed immoderates might have reason to welcome the imposition of these costs. Although

16/ It may be that the only way to separate smokers and drinkers taking risks from those not taking risks is to wait until illness develops or fails to develop. Perhaps smokers could save their tax seals and cash them in for refunds if they reach 65 without developing lung cancer.

their expenses would be greater, they would thereby remove at one stroke the most effective device held by others to justify meddling with their "chosen" way of living.17/

The negative side of this proposal stems from the fact that under its terms the only way to retain one's liberty is to pay for it. Only the poor, then, would be forced to submit to loss of privacy and freedom from pressure and regulation aimed at changing behavior. Such liberties are what make up full citizenship, and one might hold that these ought not be made contingent on one's ability to purchase them.

There are two other objections to the proposition that programs to change behavior might be justified by the need to avoid the injustice of having the prudent pay for the medical care of those with unhealthy habits. The first recalls an objection raised earlier to the paternalistic rationale: that this rationale might actually be a cover for the imposition of the particular moral tastes of those fostering regulation. And the same caution about the imposition of morals may be voiced about an even more fundamental issue: whether we, as a society, really prefer financial savings to imprudent living. Most of us engage in some unhealthful practices; those who do not are considered to be unusual. Who, then, is being protected from whom? If each of us imposes some of the burdens on others, we may achieve in a natural way a fair distribution of costs and benefits, and this would remove the responsibility of justifying modification of health behaviors by reference to the need for fairness.

A final point about the present argument for health reform may prove to be the focus of the most debate should these proposals become policy: how much intrusion or coercion for health is justified by the potential burden placed on society by a given unhealthful habit. Suppose, for example, a person regularly engaged in a habit that posed some risk of illness, and

17/ See Detmer (20).

that this would present a slight financial burden on others. Suppose further that mild reform efforts--exhortation, even a small tax on the habit--will not be sufficient to induce a behavior change. Then there are two choices: either society can put up with the burden, or the individual can be subjected to efforts that discourage the unhealthful behavior. There is clearly a limit to what would be permissible in such a situation.

The fact that illnesses caused by unhealthful habits impose financial burdens on society, then, does not automatically provide cause for adopting strong measures to change the unhealthful behavior. The principles of justice, which seem to underlie such a rationale, demand a finding of fault on the part of those with unhealthful habits. This may be difficult to establish. Even when the risks are taken by people in full control of their behavior, the social arrangements that cause their acts to have financial consequences for others may not have been freely chosen. Before coercive reform is mandated, the individual would ideally be given the option of paying for his or her habits, thus removing the link between a chosen way of life and any burden on the public. Further, if the burden argument is to be successful, it must be shown that it is not being used merely to justify the imposition of personal or even societal tastes and values. Last, some principled method must be found for determining fair correspondence between the size of the threatened burden on society and the extent of privation or intrusion involved in the reform measures.

Should this rationale for reform programs fail to withstand moral scrutiny, however, we still may not conclude that there should be no such programs. They may derive justification from some other source, such as the arguments examined in the preceding or following sections. And, most measures now being contemplated are innocuous in character, involving neither coercion, intrusion, nor deprivation.

Public Welfare

The previous section weighed the justification of coercive reforms on ground of protection of the public from unfair burdens imposed by those with poor health habits. Even if no fault is found with those whose habits are immoderate, there may be social benefits to be realized by changing their behavior. Changing behavior may simply be the most efficient way to reduce the costs of health care in this country, and the benefits derived from taking this opportunity to reduce costs may give reason to create some injustices. Further, collective security may be enhanced by reform if a larger, healthy manpower pool is the result.

Also, there may be benefits more directly related to health. If the supply of physicians and facilities should prove relatively inelastic, or if the economy would falter if too many resources were diverted to health care, it may be impossible to increase access to needed medical services. The social goal of adequate treatment for all who need it will not be realizable under these circumstances unless the actual need for medical care were reduced. Vigorous government efforts to change unhealthful habits may be seen as the most promising means to this end.

The achievement of these social goals--enhanced security, improved economic functioning, and universal access to medical care--could come at the price of limits to the autonomy of that segment of society that indulges in unhealthful living. If we do not claim to find fault on their part, it would be reasonable to insist that the immoderate owed the loss of some liberties to society as a part of some special debt, while continuing to exempt those with involuntary special needs due to genes or body chemistry. The reason for imposing a loss of freedom on the immoderate rather than upon the diabetic would be, simply, that society stands to benefit more by doing so.

Whether it is permissible to pursue social goods by extracting benefits from disadvantaged groups within society is a matter of political ideology and justice.

Perhaps even those whose ideology would not ordinarily warrant government intervention on these grounds would make an exception for reform of unhealthful habits. For even if the real motivation for the reform efforts were the achievement of the social goals mentioned above, intervention might in fact be justifiable on paternalistic grounds; and, even the intervention that is not thus justified confers some benefit in the form of promise of better health.

Two kinds of questions arise in considering the ethics of government attempts to bring about the adoption of healthier ways of living. The first is whether coercion, intrusion, and deprivation may be used as methods for inducing change. The other is how we are to decide whether a given health promotion program is coercive, intrusive, or inflicts deprivations. These questions are independent of each other. Two parties who agreed on the extent of coerciveness that might be justifiably employed in a given situation might still assess a proposed policy differently in this regard, and hence reach different conclusions on whether the policy should be put into effect.

Disagreement about the extent of coerciveness of behavior change programs is to be expected, not least because of the vagueness of the notion of coercion itself. Some of the most difficult problems addressed in the philosophical literature arise in the present context: what is the difference between persuasion and manipulation?18/ Can offers and incentives be coercive, or is coercion a property only of threats? And can one party be said to have coerced another even if the latter manages to accomplish that which the first party tried to prevent? The answers to these and similar queries will affect evaluation of various kinds of health promotion measures.

18/ See Nozick (48), Held (34), Bayles (3), and Pennock (51).

Health Education

Health education seems benign. Education provides information, and this generally increases an individual's power, because it enhances the likelihood that a person's decisions will accomplish his or her ends. For the most part, there is no inherent ethical problem with such programs, and they do not stand in need of moral justification.

However, information can be used as a tool for one party to get another to do its bidding, just as threats can. But the method is different: instead of changing the prospective consequences of available actions, education alerts the other party to previously unrecognized consequences of acts. The educator who hopes to increase healthful behavior will, of course, disseminate only information that points in that direction. It is difficult to know whether to regard this selective informing as manipulative. Theoretically, at least, people are free to seek out the other side of an issue on their own. Such measures acquire more definite coercive coloration when they are combined with suppression of the other side, which is another option open to reformers.19/

The main threat of coerciveness in health education programs lies in the possibility that these may turn from providing information to manipulating attitude and motivation. Education, in the sense of provision of information, is a means of inducing belief and knowledge. A review of the literature indicates, however, that when health education programs are evaluated, they are not judged successful or unsuccessful in proportion to their success in inducing belief. Rather, evaluators look at behavior change--the actions which, it is hoped, would stem from these beliefs.

19/ Although this most clearly recalls the banning of liquor and cigarette advertising from the airwaves, I do not believe that the suppression of information was generally involved. The advertisements did not stress the delivery of information.

There seems to be a presupposition that once people learn the facts, they will automatically change their habits. But more than knowledge is required. If health education efforts are to be evaluated favorably, health educators may begin to take a wider view of their role.20/ This would include attempts to motivate the public to adopt healthful habits, and this might have to be supplied by appeals to other interests ("Smokers are unpopular," and so on). Suggestion and manipulation may replace information as the tools used by health educators to accomplish their purpose.21/ Indeed, the job may call for actual and deliberate misinformation: since qualified messages seem to have little behavioral effect, directives may imply or even state that the scientific evidence in favor of a given health practice is unequivocal when it is not.22/

A fine line has been crossed in these endeavors. Manipulation and suggestion go well beyond providing information to enhance rational decision-making and thereby inflict a loss of personal control. Thus health education, except when restricted to information, requires some justification. The possible deleterious effects are so small that the justification required may be slight; but the requirement is there. The ethical concern for this kind of practice may become more pressing as the techniques used by educators to change behavior become more effective.23/

20/ See Rosenstock (59).

21/ American Public Health Association (1); Haefner and Kirscht (33); Milio (45).

22/ Lalonde (39).

23/ See Ubell (65). It might be objected that the kind of manipulation I am speaking of is practiced continuously by commercial advertisers, and that no justification is provided by or demanded from them. It certainly is true that these techniques are used, but this does not show that there is not a need for justification when they are used in the course of a government health promotion campaign. The fact that the commercials are tolerated may indicate not that the manipulative techniques are themselves unobjectionable, but rather that private interests

Incentives, Subsidies, and Taxes

These measures range from pleasantly noncoercive efforts, such as offering to pay citizens if they will live prudently, to measures generally regarded as coercive, such as threatening to fine them if they do not. Various measures designed to facilitate healthful living come under this heading as well: providing jogging paths and subsidizing tennis courts would be offers of a sort. Threats taking this form might include making all forms of transportation other than bicycling difficult, and making inconvenient the purchase of food containing saturated fats.

Generally speaking, justification is required only for coercive measures, not for incentives. However, the distinction is not as clear as it first appears. Suppose, for example, that the government wants to induce obese people to lose weight, and that a mandatory national health insurance plan is about to go into effect. The government's plan threatens obese individuals with higher premiums unless they lose their excess weight. Before the plan is instituted, however, someone objects that the extra charges planned for eager eaters make the program coercive, and no adequate justification for the program is found.

Instead of calling off the program, some subtle changes are made. The insurance scheme is announced with higher premiums than had been planned. No extra charges are imposed on anyone; instead, discounts are offered to those who avoid being overweight. Instead of coercion, the plan now uses positive incentives; and this does not require the kind of justification that was needed but not found for the former plan. Hence the new program is allowed to go into effect.

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enjoy freedom from regulation in their attempts to communicate with the public. The rationale for this freedom--if it exists--may not apply to government communications. The government *per se* is not an entity with interests which must be protected by rights in society; and the same holds true (officially, at least) of health education advocates, when agents of the government.

The effect of the rate structure in the two plans is, of course, identical: obese persons would pay the higher rate, slender ones the lower rate. It seems that the distinction between coercion and incentive was merely semantic. But this is the wrong conclusion. There is a real difference between coercive measures and non-coercive ones, a difference upon which much ethical evaluation must rest; the problem is in stating what that difference amounts to. A partial answer to the puzzle is that a given measure cannot be judged coercive or noncoercive without bringing in a reference to a background standard from which the measure's effects diverge favorably or unfavorably. Ultimately, the judgment required for the obesity measure would require us to decide what a fair rate would have been for the insurance; any charges above that fair rate would be coercive; and any below it incentive.24/ The rate the government announced as the standard premium might not have been the fair rate; and this shows that one cannot judge the coerciveness of a fee structure merely by checking it for surcharges.

Even if we are able to sort coercive measures from incentives, however, we may have reason to hesitate before licensing unlimited use by the government of incentives to reform those with unhealthful habits. Although a party in a position to make offers does not necessarily coerce those to whom it makes the offers, it is relatively more likely to get its way; in this sense its power increases. Increased government power over living habits would seem generally to require some justification. In particular, there is some danger that, given the present scientific uncertainty over the effects of many habits, practices might be encouraged that contribute nothing to health or even prove to be dangerous. A further problem with the use of financial incentives for healthful living is that if they are to affect the behavior of the rich they must be sizable, and this may redistribute wealth in a direction considered unjust on other grounds.

24/ For an account whose complexity honors that of its subject, see Nozick (48).

The imposition of financial penalties as a means of inducing behavior changes raises questions that have been touched on above. The chief issue, of course, is the deprivation that this method inflicts. Even where justifiably applied to induce behavior change, no more deprivation ought to be used than is necessary for that purpose; but there are administrative difficulties in trying to obey this limitation. Different people respond to different amounts of deprivation--again, the rich man will absorb costs that would deter a poorer one. The amount of deprivation inflicted ought, then, to be tailored to the individual's wealth and psychology. This may well be administratively impossible, and injustice would result to the degree that these differences were ignored.

Regulatory Measures

The coercive measures discussed above concentrate on applying pressure or influence on individuals so that their behavior will change. A different way of effecting a "reform" is to deprive self-destructive individuals of the means needed to engage in their unhealthful habits. Prohibition of the sale of cigarettes would discourage smoking at least as effectively as exhortations not to smoke or insurance surcharges for habitual tobacco use. Although they do not involve direct interaction with the individuals affected, these regulatory measures are surely coercive: they are merely one more way of intervening in an individual's decision to engage in habits that may cause illness. As such, they are clearly in need of the same or stronger justification as those involving threats, despite the argument that these measures are taken only to combat an unhealthy environment and thus cannot be counted as coercing the people who have unhealthful ways of living.25/ What distinguishes these environmental causes of illness from, say, carcinogens in the water supply, is the active connivance of the victims. "Shielding" the "victims" from these external forces must involve

25/ Terris (63). For a discussion of this indirect form of paternalism, see Dworkin (22).

making them behave in a way they do not choose. This puts regulatory measures in the same category as those applied directly to self-destructive individuals.

Conclusion

Justification must be given for certain kinds of government involvement in the reform of unhealthful ways of living. It is apparent that more is needed than a simple desire on the part of the government to promote health or reduce costs. When the measures taken are intrusive, coercive, manipulative, or inflict deprivations--in short, when they are of the sort many might be expected to dislike--the moral justification required may be complex. The principles that underlie these interventions may have limited scope and require numerous exceptions and qualifications. My goal has been to specify the justification that must be given for health promotion programs if they are not to be opposed on moral grounds. I have stopped short of declaring for or against government health reforms. Either of the latter judgments would be foolhardy, if only in view of the diversity of health promotion measures that have been and will be contemplated. One's ethical evaluation will in the end depend upon details: what measures are used, the amount of intrusion, the promised increase in health, and so on. Still, it might be worthwhile to recall a few general findings, both negative and positive.

Inherent in the subject matter is a danger that reform efforts, instead of helping people to achieve their own life goals, may become merely an imposition of the particular preferences and values of one group upon another. Although those working in medicine and related fields may focus on the medical effects of everyday habits and practices, others may not. The general public may view efforts to induce the changes in living habits as an unwarranted expansion of the medical domain. The parochial viewpoint of the health advocate can reach absurd limits: a recent address to a prominent professional health organization came close to calling for abolition

of alcohol simply on the grounds that the rate of cirrhosis of the liver had increased by 6 per 100,000 during the last forty years. In this instance, health is being imposed upon us as a goal from above; perhaps medicine would serve us best if it acted to remove the dangers from the pursuit of other goals.

Where the motivation behind health reform efforts is concern for the taxpayer rather than interest in making self-destructive persons reorder their priorities, problems of a different kind are posed. Insistence that the individual is responsible for his own health may stem from two different sources: individual habits play a causal role in producing illness, and individuals may be at fault and held accountable for bad habits and illness. The former may be undeniable, but the latter is very difficult to prove--it is even difficult to understand what such proof would be like. Unless the difficulties in this sort of view are acknowledged, diversion of attention from the various external causes of dangerous health related behavior may result. Decreased willingness to aid the person whose own behavior has resulted in their becoming ill is another possible effect.

On the positive side, two points made above bear repetition. First, although I have emphasized the difficulties in justifying coercive measures to induce lifestyle change, I have done so in the course of outlining the sort of case that might be made in support. It is entirely possible that such measures might be fair and desirable; at least, this is consistent with the principles I have claimed are relevant to deciding the issue. Second, few of the steps called for in either professional lay literature have been coercive or intrusive in nature. Little of what I have said goes against any of these. Indeed, one hopes that these measures will be funded and used to the extent they are effective. An increase in the scope of such research, education, and incentive programs may be the best result of the current attention to the role of behavior in maintaining health. This would serve two goals over which there cannot be serious dispute: enabling people to be as healthy as they want to be, and reducing overall medical need so as to make room in the health care system for all who would still require care.

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