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Just health responsibility

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ABSTRACT

Although the responsibility for health debate has intensified in several ways between Norman Daniels' 1985 *Just healthcare* and *Just health: meeting health needs fairly* of 2008, comparatively little space is dedicated to the issue in *Just health*, and Daniels notes repeatedly that his account "says nothing about personal responsibility for health".

Daniels considers health responsibility mainly in a particular luck-egalitarian version which he rejects because of its potentially unfeasible, penalising and inhumane character. But I show that he nonetheless acknowledges and endorses explicitly other dimensions of health responsibility.

I develop a wider, more nuanced and less punitive concept of health responsibility, which expands Daniels' brief consideration and is compatible with the overall approach set out in *Just health*. In its application to preventative medicine and health promotion in particular, the concept is suited to support and complement the notion that "health is special", which is central in *Just health*.

The concept of *health responsibility as co-responsibility* specifies the subjects and objects of health responsibilities. It permits the attribution of responsibility without blame and disconnects the question of assigning responsibility from decisions about entitlement to treatment or different status in prioritisation decisions. This approach secures conceptual plausibility and clarity of the concept of health responsibility, is of use in policy making, and can help reduce political tensions.

The responsibility for health debate has intensified between Norman Daniels' 1985 *Just healthcare*[1] and *Just health: meeting health needs fairly* of 2008.[2] Chronic diseases associated with, for example, obesity or alcohol consumption have become more prevalent. There is more evidence on the role of behaviour in reducing morbidity and mortality, which has led to more widespread calls for people to review their behaviour.[3,4] Health responsibility features prominently in political philosophy, and has become more pronounced in policy and practice: countries with public healthcare systems such as Germany emphasise its role, as do Medicaid programmes in the US states of West Virginia and Florida. In the UK, plans for an NHS constitution "setting out for the first time… rights and responsibilities associated with an entitlement to NHS care"[5] were recently announced. Corporations drew heavily on personal responsibility in their defence strategies in a series of US law suits, brought by lung cancer patients and obese people.[6,7]

Comparatively little space is dedicated to the issue in *Just health* (pp66–9, 148–9).[2] Since Daniels notes several times that his account "says nothing about personal responsibility for health" (pp64, 67, 147),[2] this is perhaps not surprising. However, *Just health* is less silent on the matter than it seems.

I will begin with a summary of Daniels' discussion of personal responsibility. I then sketch a concept of responsibility that builds on, and expands, Daniels' brief discussion: *health responsibility as co-responsibility*. The final section outlines how this concept can be used in policy and practice in a way that is consistent with "accountability for reasonableness" (pp71–95).[2] I seek to demonstrate that a reasonable and explicit concept of responsibility can strengthen both the general account set out in *Just health* and help make progress in political and philosophical debates about personal responsibility.

DANIELS ON RESPONSIBILITY FOR HEALTH

Daniels considers health responsibility in *Just health* in the discussion of egalitarian opportunity for welfare accounts. His summary of the argument brought by several critics against John Rawls' *Theory of justice* proceeds as follows:

> we owe… assistance or compensation only if the deficit in opportunity is the result of bad "brute" as opposed to "option" luck. If we have made certain choices… that have risks we were or should have been aware about, then others do not owe us assistance. But if the deficit is something we are in no way responsible or at fault for, then it is the kind of bad brute or cosmic luck that is unfair to us. (pp63–64)[2]

Furthermore

> the emphasis on… responsibility… was a response to the worry about social hijacking by expensive tastes…: if people choose to cultivate such preferences and are unhappy because they are not satisfied, we do not owe them assistance as we would if their welfare deficit came about through no fault of their own. But people who adopt risky lifestyle choices and expect others to assist them when ill health results have some resemblance to those who cultivate expensive tastes: owing them assistance for their "irresponsible" choices would hijack others. (pp67, 148)[2]

Daniels notes that his approach that focuses

> on protecting normal functioning says nothing about personal responsibility for health. It says that we should protect normal functioning in order to meet the needs of free and equal citizens, but it does not require us to calculate responsibility for health needs (p67).[2]

He rejects attempts at making "people bear the cost of risky lifestyle choices" (p67)[2] for several reasons: assessing someone's causal contribution is practically unfeasible (p67, fn53)[2]; corporate sector

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activities and environmental factors complicate responsibility attribution (p148)[2]; risks that might seem avoidable from some people's perspective are often part of conceptions of what makes life worth living for the persons concerned (p68)[2]; assessing responsibility is administratively burdensome, costly, intrusive, demeaning, liberty and privacy infringing, (p68)[2]; and we may "victim blame" already disadvantaged groups (pp68, 148).[2]

Daniels observes that "[s]ome of these problems might be avoided if we clarify what counts as responsibility or fault" (pp68–9).[2] He considers one particular proposal by John Roemer, which, broadly, links responsibility assessments to the degree to which a person's risk behaviour departs from standards that are typical for the kind of group a person might be assigned to.[8] Daniels dismisses the method: "[a]typicality is a poor measure of effort or desert or responsibility"(p69).[2] [i]

Ultimately Daniels concludes that

> too much emphasis on [personal responsibility] ignores egalitarian considerations central to democratic equality. Our health needs, however they arise, interfere with our ability to function as free and equal citizens. [We] must meet the[se] needs however they have arisen, since capabilities can be undermined by both bad brute and bad option luck" (p69, cf p68).[2]

Daniels considers, and rejects, responsibility almost exclusively in a particular luck-egalitarian version. In this sense, his theory might "say nothing about personal responsibility for health". However, note his acknowledgement that "[e]ven if we do not emphasise responsibility in assigning of obligations of justice, we can still appeal to that concept through incentives and education" (p69)[2] and:

> "[n]othing in our approach is incompatible with urging people to adopt healthy lifestyles; far from it. Health education is an essential part of public health on the account developed here. Incentives, and not just education, are also important tools of public health" (p148, cf pp35, 150).[2]

In principle, Daniels' theory can therefore allow for an exploration of the scope of health responsibility beyond particular penalising luck-egalitarian versions. I will attempt such a development next.

RESPONSIBILITY BEYOND MERE ATTRIBUTION OF BLAME

The meaning(s) of health responsibility (I)

The debate about health responsibility takes place in two main fora: political philosophy and health policy. Within political philosophy, responsibility features in (luck) egalitarianism, but also in communitarian[9] libertarian[10] and contractualist[11] approaches. In policy, three principal strands can be distinguished. First, the immediate context of codified health policy: A range of detailed responsibilities are set out in laws such as the German Social Security Schedule;[12] in binding codes such as West Virginia's Medicaid Membership Agreement,[13] or in non-binding statements such as the Scottish NHS' Patients' Charter.[14] Secondly, there are political documents: numerous white papers by both labour and conservative UK governments emphasised responsibility,[15–17] as did the US Public Health Service's *Healthy people* reports since 1979. Thirdly, there are academic contributions, generally differing in methodology and theory from the political philosophy approaches, including applied ethics, sociology, health law, economics, psychology, public health and epidemiology.

I cannot, here, review in depth the respective characterisations of health responsibility. However, for the present purpose this is not necessary. Further to an outline of different notions of responsibility in policy documents that is provided elsewhere,[18] boxes 1 and 2 give a sufficient illustration of the many senses that the concept has.

The need for a fuller concept of health responsibility

As already highlighted by Daniels', the central focus in the health responsibility debate is on justifying or criticising responsibility in relation to controversial negative sanctions, such as denial of treatment. While there are good reasons for this preoccupation, it should not detract from the fact that in

Box 1: Different meanings of the phrase "X is responsible for p" in the context of healthcare

In theory, policy, practice and everyday language, responsibility for health has a range of different meanings. Sometimes distinct notions are made explicit. Other times, several meanings may be implied simultaneously, whether explicitly or implicitly. Much confusion arises from not distinguishing clearly between these different meanings, or not being explicit about which sense is meant, in endorsements or criticisms.

In a forward looking (prospective) sense, when we say "person X is responsible for action p", and p is some beneficial event, whether for X, others, or the healthcare system, we may mean one of several things, including the following:

- X should do p as no-one else can, in principle, (or will, practically) do p for X (eg, exercise more, eat less).
- X should do p, as this will be good for the health of X, the health of others, or the operation of the healthcare system.
- X should do p, as distributive justice demands this, even though X won't be penalised if p is not done.
- X should do p, as distributive justice demands this, and X knows that a penalty will be imposed if p is not done.

In a backward-looking (retrospective) sense, when we say "person X is responsible for action p", and p is some negative event, whether for X, others, or the healthcare system, we may mean one of several things, including the following:

- X has played a certain causal role in having brought about p.
- X has played a certain causal role in having brought about p, and should recognise this.
- X has played a certain causal role in having brought about p, should recognise this, and try to avoid doing so in the future.
- X has played a certain causal role in having brought about p, should recognise this, try to avoid doing so in the future, and make good any costs (with or without being blamed) for reasons of distributive justice.
- X has played a certain causal role in having brought about p, should recognise this, try to avoid doing so in the future, make good any costs, and, in cases where X requires treatment, may be given a lower priority than patients whose behaviour played no, or a lesser role in contributing to their healthcare needs (typically with attribution of blame).

While the focus in the above examples of retrospective responsibility-attributions is on *negative* health outcomes, backward-looking assessments may also relate to *positive* behaviour, for example, where rewards or bonuses are provided.

[i] And one might add that under purely practical considerations it seems very difficult to find groups or clusters of people that are both sufficiently similar and sufficiently large, to describe meaningfully departures from some mean.

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Box 2: Health responsibility in philosophy and ethics

A range of different characterisations can be found in the literature. The following examples have been set out to be applied in the context of healthcare, or are otherwise directly applicable:

- ''causal… responsib[ility vs] responsib[ility]… [as] being at fault and accountable''[19]
- ''role responsibility…, causal responsibility…, responsibility based on liability''[20]
- ''responsib[ility] for… choices…[vs] responsib[ility] for the consequences of… choices''[21]
- ''prospective… [vs] retrospective responsibility'',[22] ''forward-looking… responsibility [vs] backward-looking… responsibility''[23]
- ''substantive responsibility… [vs] responsibility as attributability''[11]
- ''agent responsibility [vs] consequential responsibility''[24]
- ''individual responsibility for reasons of… fairness, … utility… self-respect… autonomy… human flourishing.''[25]

law, policy and medical practice, a much wider and more nuanced range of responsibilities can be found, many of which can be viewed as reasonable constituents of a plausible concept of health responsibility. Discussing health responsibility exclusively in the luck-egalitarian context risks reducing a much richer concept of responsibility to just one sense. An overly narrow focus may, first, overlook some positive notions of responsibility, such as its role in health education and promotion, acknowledged by Daniels. Secondly, it may mean that an analysis of ethical issues associated with other types of responsibility-driven policies—such as providing incentives or bonuses—is neglected.[19 26] These issues may be somewhat less spectacular, but are nonetheless significant for discussions about responsibility and fairness in healthcare.

Furthermore, it is noteworthy that both proponents and opponents of health responsibility are usually reluctant to accept that it can make sense to say that someone is responsible for a certain health outcome in a non-trivial sense, but should not be held accountable. Especially in political debates, the argument on the left is typically that individuals cannot be held responsible as external constraints (socio-economic status, access to healthcare, etc) thwart responsibility ascriptions, whereas as the right generally takes a ''get-real'' view according to which the environment matters, but ultimately people are seen as free agents, aware and hence accountable of the consequences of their actions. Consequently, the argument about holding people accountable seems to turn mainly on proving, in an either-or fashion, that individuals are responsible (or not) for particular actions, and much of the academic debate is centred around this enterprise.

However, it is not implausible to explore an in-between position, in which it can make sense to say that people are responsible for an action, but should nonetheless not be held accountable. Four examples illustrate this. First, we can recognise a person's *partial* causal responsibilities in having contributed to a negative health outcome. For example, we may appeal to a factory worker living near an industrial site who is a heavy smoker and presents with lung problems to stop smoking (while making no attempt at claiming that the respiratory problems are attributable to him alone). Secondly, we can follow Daniels in noting that all people take risks that may seem avoidable from the perspective of others, and that it may not be feasible to hold everyone accountable, and unfair to impose penalties on only some (p68).[2] Some may over-eat, others engage in adventure sports, sunbathe excessively or pursue an overly ambitious and stressful professional career. Again, while there may be legitimate questions about imposing negative sanctions, we are not committed to abandon a concept of health responsibility wholesale. Thirdly, we may also be quite clear that in a meaningful sense, a higher prevalence of smoking, obesity and alcohol among the least advantaged socio-economic quintile is a matter of personal responsibility, while arguing that, *solidarity* should guide us in determining questions around access to treatment, and, generally, prompt us to provide it.[27] Fourthly, we may waive holding people accountable on more strategic grounds, in order to enable them to act responsibly at a later stage, or in a different context.[25] These approaches allow us to meet Daniels' goal of ''treating people's needs however they have arisen'', while recognising, but not exaggerating the role of personal responsibility. I now turn to the question of what a wider, more nuanced concept of health responsibility might look like.

The meaning(s) of health responsibility (II): four dimensions

According to Micha Werner's[22] general characterisation, the concept of responsibility has at least four dimensions. *Someone* (subject of responsibility) is responsible for *something* (object of responsibility) towards *someone* or some *entity* (judicial authority) in view of particular *normative standards* (normative background). This characterisation provides a suitable starting point. Further to Georg Marckmann's helpful initial development of the concept for healthcare debates,[28] I will ''unpack'' it for the present context in somewhat more detail as follows.

Subjects of responsibility are, firstly, patients. However, as Daniels' emphasis on education and incentives highlights, people in other health states may also have obligations. These are the healthy; those who are unwell, but not yet in need of treatment; and those who are recovering from an illness. These four groups are also commonly recognised as health responsibility subjects in policy and law.[18]

Objects of responsibility are typically past or future actions that relate to one's own health, the health of others, or the operation of the healthcare system. All three dimensions are again commonly found in policy and law.[18]

- Self-directed responsibilities may concern leading a healthy life as part of a conception of a ''good life'', or, in a more instrumental sense, to achieve particular life plans, or to maximise one's options in a society based on fair equality of opportunity (thus realising the value implied in the notion that ''health is special'').
- Responsibilities towards others can take the form of not harming them. They may also relate to caring for health needs of those under one's guardianship, such as children, protecting and promoting their (future) opportunity ranges. Donating blood or organs are further forms of obligations towards others, if arguably much weaker ones than not harming them.
- Responsibilities towards the healthcare system concern contributing to its fair and efficient operation so that it can serve as many people in need as possible. For example, missing appointments, or not cancelling them in time, may deprive others of medical attention, and may have considerable financial cost,[16] as may wasting medicines or using services unnecessarily.

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The judicial authority

Where health responsibilities are codified explicitly, the issuing authority or its agents (healthcare providers or medical professionals) may carry out assessments of whether the obligations have been met, and whether some form of positive or negative response should follow. But obligations may be also be set out merely as ideals or aspirations.

Health responsibility as co-responsibility

Before turning to the remaining question of the normative standards, that determine which responsibilities are acceptable and which ones are not, I will summarise the key elements of the discussion so far in order to set out the core of what I take to be an appropriate concept of responsibility in the healthcare context: *health responsibility as co-responsibility*.

Health responsibilities concern one's reasonable prospective and retrospective obligations as a healthy person, patient or reconvalescent, to lead a healthy life, to respect the health of others, and to contribute to an efficient healthcare system, insofar as available choices and external factors permit this.

Prospective responsibilities relate to appeals to act in a certain way in the future. Retrospective responsibilities relate to an assessment of past behaviour in relation to previously specified obligations. Retrospective assessments can have positive consequences in the form of praise, or financial or other bonuses that may be offered as incentives. Retrospective assessments may also have a negative character, for example, attributing a certain degree of causal responsibility for poor health; telling people that they should have behaved differently; using measures such as not-for-payment bills to convey the cost of treatment; requiring (higher) co-payments; or assigning lower priority in treatment. (While the latter two options would not generally be viable under Daniels' account, they are listed here for the purpose of illustrating the range of possible options).

Since health is affected both by personal behaviour and factors generally beyond immediate individual control (socio-economic status, access to healthcare, infrastructural arrangements, etc), it is neither an exclusive matter of personal or social responsibility. As the element of personal control admits of degrees, conceptually, personal responsibility also needs to admit of degrees. By necessity, health responsibilities are therefore *co-responsibilities*.[ii] This is relevant both for the assessment of the causal factors that led to a particular health state, as well as for attributions of praise or blame, and decisions about possible positive or negative sanctions. The degree of responsibility is also relevant in deciding about the about the appropriate role of other values, such as solidarity.

In one sense, this concept might seem disappointingly vague and bland. However, it appears to be the most appropriate model to capture the various interwoven dimensions of health responsibility that can reasonably be subsumed under the term, and to do justice to the fact that both conceptually and in practice, attributing responsibility must admit of degrees, despite the fact that holding people accountable must be a matter of either/or. I next turn to the question of how particular forms of health responsibility might be justified.

[ii] Note that the concept of co-responsibility also features in article 1 of the German Social Security Code (SGB V), although in a somewhat different and narrower sense, as responsibility for health is viewed as shared between the healthcare system and patients.

JUSTIFYING HEALTH RESPONSIBILITY IN PRACTICE

Comprehensive theories or accountability for reasonableness

A normative background for justifying particular forms of health responsibility in practice might, first, be provided by one of several philosophical theories. The output would be fairly predictable in the case of luck-egalitarianism, communitarianism or libertarianism. While, elsewhere, I explore the potential of Thomas Scanlon's version of contractualism in this context, here, I return full circle to Daniels' *Just health*. For it seems that the role of personal responsibility could also be determined within an adapted accountability for reasonableness approach.

Accountability for reasonableness is set out in *Just health* in response to the third focal question: "How can we meet health needs fairly when we can't meet them all?" The gist is that in view of inevitable substantive disagreement about this question, general *principles* of justice need to be supplemented with fair *processes* for limit-setting (p96, cf p101).[2] accountability for reasonableness requires meeting four conditions concerning: publicity; relevance; revision and appeals; and regulation (pp110–11).[2] The relevance condition is specified in its briefest form as follows:

> The rationales for limit-setting decisions should aim to provide a reasonable explanation of how the organisation seeks to provide "value for money" in meeting the varied health needs of a defined population under reasonable resource constraints. Specifically, a rationale will be "reasonable" if it appeals to evidence, reasons and principles that are accepted as relevant by [fair minded] people who are disposed to finding mutually justifiable terms of cooperation. Where possible, the relevance of reasons should be vetted by stakeholders in these decisions… (pp110, cf pp109, 115–123).[2]

One way of making progress with the question of personal responsibility for health could be taking the above concept of "health responsibility as co-responsibility" as a basis, and deciding about particular uses in a manner consistent with accountability for reasonableness, particularly with the relevance condition (cf pp147–8, 116).[2]

Health responsibility: five tests under the relevance condition

In setting out reasons for binding or non-binding prospective and retrospective health responsibilities directed towards oneself, others, or the healthcare system, the following five "tests" may provide useful guidance. They call for justification in relation to evidence and rationale; feasibility and intrusiveness; attributability and choice; coherence; and affected parties.

Evidence and rationale test

Whether personal responsibility is proposed on fairness grounds, to prevent moral hazard behaviour, or for reasons of utility, self-respect, autonomy, or human flourishing,[25] evidence is required that a particular policy will be capable of realising these values. For example, an argument on fairness grounds might be that smokers should contribute more to healthcare costs. This would require data showing that smokers do in fact generate higher costs than healthy people. But if evidence points the opposite way,[29] another value might be required, or the policy needs to be abandoned. Being explicit about evidence and underlying rationales is crucial in justifying and securing support for particular responsibility-based policies, and to avoid "legal moralism",[19] where particular behaviours are penalised simply because policymakers have a dislike for them, and/or see responsibility-appeals as a convenient way of increasing government revenues.

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Feasibility and intrusiveness test

Promoting responsibility is often seen as synonymous with imposing highly intrusive, unjustified paternalistic measures, and Daniels cites this feature as one reason for his reluctance to give it much emphasis in health policy (p68).[2] However, this is far from necessary, and Daniels also acknowledges the role of providing information, education and incentives (p69),[2] accepting furthermore that such measures may be used in appeals to responsibility that "urg[e] people to adopt healthy lifestyles" (p148, cf pp35, 150).[2] Other options that would rank higher on a "ladder of intervention"[30] would include disincentives such as taxes, and ultimately infringing civil liberties (say, quarantining people with highly infectious harmful diseases who refuse the obligation not to harm others). The feasibility and intrusiveness test would require choosing the least intrusive, while most likely to be effective, measure.

The test also requires an assessment of the administrative and organisational effort necessary to implement health responsibilities. It may be that although some types of responsibility are reasonable and can be clearly specified, their enforcement would simply be disproportionate. In such cases, setting them out in a prospective non-binding form might be preferable.

Attributability/degree of choice

As outlined above, retrospective causality-assessments and attribution of praise and blame for health states are far from straightforward, due to the complex interplay of causal and other factors. In awarding bonuses or incentives, this may be less relevant, and some ambiguity may be acceptable. But not in the case of negative sanctions. Marckmann considers the example of responsibility for sun-exposure related melanoma in this context. Because of varying skin-sensitivity and problems of causal attribution, he cautions against retrospective sanctions or penalties, but emphasises appeals to prospective responsibilities. Reasonable obligations to oneself, others (say, children) and the healthcare system would include limiting sun-exposure, and carrying out the so-called ABCD self-diagnoses. Tailored education campaigns in Australia led to a reversal in trends of melanoma-related mortality.[28]

Questions of attribution are less important in relation to responsibilities towards a healthcare system. Here, the focus is more on the range of choices people have. For example, provided people are able to schedule, cancel and re-schedule medical appointments at convenient times, so that, with Scanlon, conditions obtain that could not be reasonably rejected,[11] negative sanctions such as penalty payments for missed appointments could, in principle, be considered as a way of promoting fair use of healthcare services. However, the capacities of particular healthcare users to benefit from these choices need to be considered carefully. It could be unreasonable to expect people with certain addictions or mental problems to comply with these obligations. The attributability/degree of choice test therefore needs to be particularly sensitive to the issues around victim blaming, and the considerations introduced above around attributing responsibility without holding people accountable, for example based on the value of solidarity, are especially relevant here.

Coherence test

Justice, in one meaning, demands treating similar cases similarly. Particular forms of health responsibility therefore need to be compared to other health responsibilities, and to obligations in social policy more widely. A wider comparison may furthermore be interesting since many of the hard questions in apportioning responsibility also arise in other contexts, such as criminal, tort and liability law. For example, in the UK, *contributory negligence* can lead to reductions in awards in personal injury claims brought by victims of traffic accidents who failed to wear a seat belt. Such comparisons do not mean that identical standards need to be implemented in healthcare—there may be morally relevant differences. But ultimately, a coherent use of responsibility would be the ideal outcome, whether this means similar, or distinct policies.

Affected parties test

Health responsibilities may be communicated or enforced through individuals or agencies. Teachers may be involved in education campaigns. GPs may (or may not) appeal to patients' responsibilities to change their behaviour. However, depending on the organisation of a health system, and the type of responsibility, doctors may also be required to pass on information to sickness funds or similar agencies about whether or not people comply with particular obligations, which may significantly change the doctor-patient relationship.[21 31–32] The implications of particular responsibilities for the agents involved, and the relationships between them, therefore require close scrutiny.

CONCLUSION

A concept of health responsibility that is to be fair and useful in the context of health policy must be wider, more nuanced and less punitive than the luck-egalitarian version Daniels rightly rejects. *Health responsibility as co-responsibility* presents one alternative. The concept specifies the subjects and objects of health responsibilities, permits the attribution of responsibility without blame, and to disconnect the question of assigning responsibility from decisions about entitlement to treatment or different status in prioritisation decisions. This secures conceptual plausibility and clarity and can help reduce political tensions. In practice, the concept may be realised through an accountability for reasonableness approach: in this sense it constitutes and may lead to just health responsibility.

While the approach sketched out here clearly requires further development and detail, I contend that it is compatible with Daniels' account set out in *Just health*.[2] Moreover, it is suited to strengthen his theory in its application to preventative medicine, health promotion and fair use of healthcare systems, as these areas inevitably require consideration of the scope and limitations of personal responsibility. Health responsibility as co-responsibility is therefore well suited to help realise "normal functioning" and to support and complement Daniels' central notion that "health is special". While it is understandable that Daniels seeks to avoid in *Just health* the unduly penalising consequences often associated with health responsibility in the luck-egalitarian debates, and therefore insists that his approach is silent on the issue of responsibility, I have tried to show, first, that he in fact endorses particular notions of responsibility, and secondly that expanding his brief discussion can lead to a reasonable concept of health responsibility that goes beyond mere blame and denial of treatment.

Healthcare reforms in Germany[12] the UK,[33] the USA and elsewhere, as well as proposals such as the recent EU Health Strategy[34] all centrally emphasise the importance of prevention. Over the next years, this focus will raise a new and different debate about health responsibilities, as successful prevention requires a high degree of cooperation from the population. To maximise the chances of a win-win situation in which healthy people can function as "free and equal citizens" (p69),[2]

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maximising their opportunity range, on the one hand, and the efficiency of healthcare systems on the other, clarity is required about the kind of health responsibilities that are reasonable, and the ones that are not. The five tests proposed here are set out as one preliminary step in this direction.

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