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The Individual, Health Hazardous Lifestyles, Disease and Liability

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"Who said the health service could not resolve its funding crisis? Britain’s cardiac surgeons have come up with a solution that will solve the government’s problems at the stroke: the withdrawal of treatment for self-inflicted sickness. Surgeons at two separate medical centres were reported last week to have withdrawn non-urgent coronary bypass operations from patients who were refusing to give up smoking."

INTRODUCTION

The health care system of the United States is in disarray and President Clinton’s promise for a national health plan never came to fruition.


Malcolm Dean, London Perspective: Self-Inflicted Rationing, 341 THE LANCET 1525, 1525 (1993) (attributing the surgeons' actions to "limited NHS [national health system] resources, self-inflicted damage by smokers, an increased failure rate with smokers, and the fact that treating smokers meant resources were being denied to non-smokers"). See also K.C. Calman, The Ethics of Allocation of Scarce Health Care Resources: A View From the Centre, 20 J. MED. ETHICS 71, 73 (1993) (evaluating the allocation of resources in Britain, author states "[l]ifestyle, notably in relation to cigarette smoking has been suggested as a factor which can be used in determining which patients should be treated, and what resources should allocated to them").

Lawrence O. Gostin, Securing Health or Just Health Care? The Effect of the Health Care System OnThe Health of America, 39 ST. LOUIS U. L.J. 7, 43 (1995)[hereinafter Gostin, Securing Health] (citing President Bill Clinton, The State of the Union Address [Jan. 25, 1994], in WASH. POST. Jan. 26, 1994, at A12. "I know there are people here who say there’s no health care crisis . . . . Tell it to the 58 million Americans who have no coverage at all for some time each year. Tell it to the 81 million Americans with . . . preexisting conditions . . . . Tell it to the small businesses burdened by skyrocketing costs of insurance . . . . Or tell it to the 76 percent of insured Americans, three out of four whose policies have lifetime limits, and that means they can find themselves without any coverage at all when they need it the most").

Thirty-seven million Americans are without health care, neonatal mortality is comparable to third world countries, health care costs now exceed fourteen percent of the gross national product, and life expectancy is lagging behind other developed countries. Based on these facts it is no surprise that issues related to cost containment are continually surfacing. Avenues for cost reductions are constantly being explored and modified. Within this emerging system individuals, corporations, insurance companies, and hospitals are vying to shift the blame and the medical costs to some other source. As a result, there is a prevalent trend connecting the individual, disease, and responsibility. Lifestyles and behaviors are being promoted as an individual's choice which one should modify in order to prevent disease. For almost two decades discussions

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4Schuler, supra note 3, at 783.
5See Gostin, Securing Health, supra note 2, at 24 (explaining that "[t]he United States ranks below average among economically developed countries on currently used measures such as infant mortality and low birth weight babies, life expectancy, and years of health life as a proportion of life expectancy") (citing U.S. PUBLIC HEALTH SERV., U.S. DEP'T OF HEALTH & HUMAN SERVICES, HEALTH PEOPLE 2000: NAT'L HEALTH PROMOTION & DISEASE PREVENTION OBJECTIONS 6, 9 (1991)). See also Emily Friedman, The Uninsured: From Dilemma to Crisis, 265 JAMA 2491, 2495 (1991) (noting that "[m]any of our health status indicators are lagging or beginning to lag behind those in the rest of the developed world—and, indeed, in some of the Third World").
6Barbara Sande Dimmitt, The State of Health Care In America, 1996 BUS. AND HEALTH MAG. 6, 6. See Gostin, Securing Health, supra note 2, at 25 ("[T]he expenditure on health care in the United States represents approximately 14 percent of the nation's gross domestic product. Health care expenditures are expected to reach $1.7 trillion, between 16 and 18 percent of the gross domestic product, by the end of the decade if effective controls are not instituted").
9See Robert L. Schwartz, Lifestyle, Health Status, and Distributive Justice, 3 HEALTH MATRIX 195, 196 (1993) (explaining that the reaction to the health care crisis is to begin searching for scapegoats).
10Id. at 197. See Robert Crawford, You Are Dangerous To Your Health, 8 SOCIAL POL'Y 11, 14 (1978) [hereinafter Crawford, Dangerous Health] (describing that the "victim-blaming ideology will help justify shifting the burden of costs back to users. If you are responsible for your illness, you should be responsible for your bill as well").
11Id.
12See Schwartz, supra note 9, at 197.
have focused on proclaiming that individuals who participate in health diminishing lifestyles ought to be held responsible for their diseases.14

The spectrum of suggestions for the perpetrators of health hazardous behaviors covers a range of proposals.15 The repercussions can take the form of complete denial (as in the Great Britain case quoted above),16 rationing of health care when resources are scarce,17 or assumption of

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14See Gerald Dworkin, Taking Risk, Assessing Responsibility, HASTINGS Ctrl. REP., Oct. 1981, at 31 (discussing the concerns about responsibility and disease); see also Schwartz, supra note 9, at 197-98 (discussing concerns about responsibility and disease). See also Robert M. Veatch, Voluntary Risks to Health: The Ethical Issues, in ETHICAL ISSUES & MODERN MED. 507, 507-08 (J. Arras & R. Hunt, eds., 2d ed. 1983) [hereinafter Veatch, Voluntary Risks] (discussing that "[a] number of proposals have been put forth that imply that individuals are in some sense personally responsible for the state of their health. The town of Alexandria, Va., refuses to hire smokers as fire fighters, in part because smokers increase the cost of health and disability insurance . . . . Additional health fees on health-risk behavior calculated to reimburse the health care system would redistribute the burden of the cost of such care to those who have chosen to engage in it. Separating health insurance pools for persons who engage in health-risk behavior, and requiring them to pay out of pocket the marginal cost of their health care is another alternative. In some cases the economic cost is not the critical factor, it may be scarce personnel or equipment. Some behaviors might have to be banned to free the best neurosurgeons or orthopedic specialists for those who need their services for reasons other than for injuries suffered from the motorcycle accident or skiing tumble"); see also Robert Veatch, Who Should Pay for Smokers' Medical Care?, HASTINGS Ctrl. REP., Nov. 1974, at 8 [hereinafter Veatch, Who Should Pay] (describing that "[t]he National Anti-Smokers Protection League has petitioned DHEW [Department Health, Education and Welfare], claiming that it is unjust for non-smokers to pay the cost of health care required for smokers as a result of their smoking (i.e., cancer, emphysema, heart attack), and they propose that a health tax be levied on smoking materials"); see also John H. Knowles, Responsibility for Health, 198 Sci. 78, 78 (1977) (describing that the"[p]revention of disease means forsaking the bad habits which many people enjoy -- overeating, too much drinking, taking pills, staying up at night, engaging in promiscuous sex, driving too fast, and smoking cigarettes -- or, put another way, it means doing things which require special effort -- exercising regularly, improving nutrition, going to the dentist, practicing contraception, ensuring harmonious family life, submitting to screening examinations"); see also Willard G. Manning, Ph.D., et al., The Taxes of Sin: Do Smokers and Drinkers Pay Their Way?, 261 JAMA 1604, 1604 (1989) (describing that "[p]oor health habits, such as smoking and heavy drinking carry costs not only for smokers and heavy drinkers, but for everyone else as well. Concern about these costs has prompted not only health-promotion efforts, but also proposals to increase both federal and state excise taxes on cigarettes and alcohol"); see also Michael F. Bierer, M.D., MPH & Nancy A. Rigotti, M.D., Public Policy for the Control of Tobacco-Related Disease, 76 MED. CLINICS OF N.A. 515, 524 (1992) (discussing "Proposition 99, the Tobacco Tax and Health Promotion Act, was passed by citizen referendum in California in 1988. The law raised the state excise tax on cigarettes by an additional 25 cent per pack. Revenues raised by the tax, estimated at nearly $600 million per year, go into a Tobacco Product Surplus Fund").


16Dean, supra note 1, at 1525.

costs (including taxing, paying higher insurance premiums, or altering pre-existing insurance plans). 18 Certainly the increasing costs of health care warrant restricting unlimited and wasteful use of resources; 19 however, connecting the individual and responsibility is not the only way to deal with the health care crisis. In order to find the individual "responsible" for diseases related to behaviors, two steps must be fulfilled. First, the individual must be found culpable, which means that the "harm is in some way the product of some faulty aspect of the person or his or her conduct." 20 Second, the individual must be found liable, which means that "certain consequences do or ought to flow from this first judgment [culpability]." 21 This article will examine both steps - culpability and liability - and will explain why the various justifications for these two steps are inadequate.

The initial discussion will cover the factors contributing to the current trend that suggests penalizing individuals for health hazardous behaviors. Additionally, the current state of insurance and resource allocation will be evaluated in relation to the health hazardous behaviors. The two steps will be discussed, finding culpability and liability, and the downfalls to the differing possible justifications will be analyzed. Then the potential implications of the systems of liability for health hazardous behaviors will be discussed and concluded with how the liability for health hazardous behaviors is not justified.

BACKGROUND

The Reason the Trend of Finding Liability for Health Damaging Behaviors has Emerged

The initial trend toward patient responsibility for disease was spawned by the state of health care in the late 1970s. 22 Three crises besieged health

20 Dworkin, supra note 14, at 28.
21 Id.
22 See Robert Crawford, Sickness As Sin, 80 HEALTH POL’Y ADVISORY CTR. BULL. 10, 12 (1978) [hereinafter Crawford, Sin] (explaining why this ideology gained popularity at this "[p]articular historical point can only be understood by examining the growing tensions within the health care system and the role such an ideological approach will play in resolving them. Most simply stated, the crises of medicine and health in the late 1970s are three: the crisis of cost, the
care at this time: cost, access and medical efficacy. First, health care expenditures were incessantly increasing. This directly affected United States corporations because most health benefits are obtained through one’s employment. As a consequence of escalating health care costs, employers began to examine the monetary outflow for medical care and concluded that the level was unacceptable. Businesses started to search for cost-effective health care packages for their employees and began to encourage employees to take responsibility for their health.

Second, access to health care became a major issue. Health care began to be viewed as an individual right. The inability of the impoverished populations to receive adequate health care became a central focus. Initially, the escalating costs of health care did not deter the goal for universal accessibility. The supporters of the campaign did not judge the crisis of access and the crisis of medical efficacy which has begun to focus attention on the social causation of disease”).

Mary Ostrer, et al., Insurance and Genetic Testing: Where Are We Now?, 52 Sci. 565, 568 (1993). See Crawford, Dangerous Health, supra note 11, at 12 (discussing that in 1975, General Motors proclaimed that health care costs for their employees exceeded expenditures to their primary supplier of metal, U.S. Steel). See also MORREIM, supra note 8, at 8 (describing a 1984 comparison between U.S. and Japanese autoworkers’ hourly wages, which revealed similar earnings with the exception of fringe benefits. Fringe benefits, the most costly of which is health care, increased the hourly wage of the U.S. autoworker to $22/hr., whereas the wage of the Japanese autoworker maintained at $13.50/hr.).

Crawford, Sin, supra note 22, at 13. See MORREIM, supra note 8, at 26 (identifying this push for employee responsibility Morreim notes that “initially their [businesses’] strategies focused on increasing employees’ responsibility for health and health care. Employees’ increased responsibility took several forms. Foremost, they were required to pay higher coinsurance, copayments, and deductibles. Beyond this, firms have encouraged employees to adopt healthier lifestyles by instituting on-the-job wellness education. Some corporations have offered financial incentives to shed pounds, discard cigarettes, buckle seat belts, and reduce drinking habits, while others outright forbid or substantially restrict their employees’ use of tobacco or other unhealthy substances”).

Crawford, Sin, supra note 22, at 13 (describing that “[t]he late 1960s and early 1970s was the rise in political demands for unhindered access to medical services. Growth reinforced these demands as did years of propaganda by a medical and research establishment which promoted medicine in almost religious terms”). See also Friednman supra note 5, at 2491 (discussing the continuing dilemma of access Friedman notes that “[p]robably no health policy issue of this century (with the possible exception of insuring and structuring long-term care, which affects far fewer people) has proven as intractable as access to acute care for Americans who lack coverage for the cost of that care”).

Crawford, Sin, supra note 22, at 14. Id. at 13-14. Id. at 14
the cost crisis as problematic in and of itself.\textsuperscript{32} The escalating medical costs were viewed as troublesome solely because the costs were a barrier to availability.\textsuperscript{33} Eventually, the endeavor for individuals' rights to health care was supplanted by the reality that accessibility to more people compounded and perpetuated the problem of escalating costs.\textsuperscript{34}

Lastly, the medical profession began to realize that there existed a crisis of social causation.\textsuperscript{35} The field of medicine that was once touted as capable of solving all health problems started to acknowledge its own limitations.\textsuperscript{36} Plainly, the abilities of medicine were oversold and there was a realization that medicine could not solve all health problems.\textsuperscript{37} Medicine's failure to find cures for plaguing diseases, such as cancer, increased awareness of environmental and occupational hazards that were associated with disease.\textsuperscript{38} This revelation of medical limitations became a threat to corporations that were producing the environmental and occupational hazards.\textsuperscript{39} This trend connecting individual and responsibility surfaced in an attempt to halt the growth of health care costs, to identify medicine's limits of curing disease, and to divert attention away from health hazards that corporations had created.\textsuperscript{40}

The Current Health Care System and Penalties: Insurance and Resource Allocation

The three major forms of penalties for health hazardous behaviors include: denial of health care, rationing of health care when resources are scarce, denial of health insurance, and resource allocation when resources are scarce.

\textsuperscript{32}Id.
\textsuperscript{33}Id. at 13-14.
\textsuperscript{34}See Crawford, Dangerous Health, supra note 11, at 13 (noting the "cost of medical services and the fiscal crisis are making services more difficult to obtain and are forcing a retreat from public programs").
\textsuperscript{35}Crawford, Sin, supra note 22, at 14.
\textsuperscript{36}Id.
\textsuperscript{37}Id.
\textsuperscript{38}Id.
\textsuperscript{39}Id. See Daniel Wikler, Coercive Measures In Health Promotion: Can They Be Justified?, 6 HEALTH EDUC. MONOGRAPHS 223, 224 (1978) (noting that "[a] crusade against illness-producing behavior may distract public attention from the need to remove environmental hazards to good health, such as pollution and unsafe working conditions").
\textsuperscript{40}See Crawford, Sin, supra note 22, at 15 (describing that the lifestyle proponents' emphasis "should not be on overhauling our work or community environments, nor on changing the structure of work in our capitalist economy; instead, the focus must be on changing individuals who live and work within those settings . . . Further, by focusing on the individual, victim-blaming assertions perform the classical role of individualist ideologies in obscuring the class structure of work and workers' lack of control over working conditions").
and assumption of costs. Fortunately, the first type of penalty, which includes complete denial of health care based on health hazardous behaviors, has not been documented in the United States. However, proposals for the second type of penalty suggest that when resources are scarce, those individuals with health hazardous behaviors should not receive the same priority as those without health hazardous behaviors. Some suggestions place "considerable emphasis" on the individual's responsibility for health. One example of this idea is the allocation of livers for patients who are alcoholics and need a liver transplantation. This topic was publicly debated when Mickey Mantle and Larry Hagman received liver transplants. When rationing expensive life-saving treatment one way to allocate scarce resources is to consider "persons who through their own choices increase the cost of care."

The third type of penalty includes forcing the individual to assume the financial burdens that presumably are caused by the unhealthy

41Dworkin, supra note 14, at 30-31. See Schwartz, supra note 9, at 203 (describing the ways that an individual could bear the burdens of lifestyle choices).
42See Schwartz, supra note 9, at 217 (giving "lower priority to that health care claimant [the one who partakes in health hazardous behaviors]"). For general discussion of rationing of health care, see David Orentlicher, Destructuring Disability: Rationing of Health Care and Unfair Discrimination Against the Sick, 31 HARV. C.R.-C.L. L. REV. 49 (1996).
43See Robert H. Blank, Regulatory Rationing: A Solution to Health Care Resource Allocation, 140 U. P.A. L. REV. 1573, 1583 (1992) (describing that "given the large proportion of health care expended on illnesses that are linked to lifestyle choice, however, any rationing policy, if it is to be effective, must place considerable emphasis on the ultimate responsibility of the individual, not only for his or her own health, but also for reducing the overall costs to society").
44See Kinkopf-Zajac, supra note 17, at 534 (discussing utilizing alcoholism in an assessment "if the medical outcome was or will be detrimentally affected"). See also Allen v. Mansour, 631 F. Supp 1232, 1239 (E.D. Mich. 1986) (holding that "the two-year abstinence requirement is arbitrary and unreasonable" when denying an alcoholic plaintiff a liver transplantation).
45See Henry Silverman, Who Deserves to Get New Organs?, THE SUN (BALTIMORE), July 9, 1995, at 1F (noting that "[d]ebates about making people suffer the consequences of their voluntary, unhealthy lifestyle choices recently surfaced when Mickey Mantle received a transplant to replace his liver, which had been severely compromised by years of heavy alcohol abuse"). See also Abigail Trafford, Sick Celebrities and Our Common Lot, WASH. POST, June 20, 1995, at Z06 (pointing out that "Mickey Mantle forces us to confront difficult moral and medical choices in health care. He symbolizes the role of behavior in getting sick—and in getting better"). See also Mark D. Somerson, New Transplant Rules for Livers Criticized, COLUMBUS DISPATCH, Jan. 20, 1997, at 1C (noting that "critics say the new policy punishes alcoholics and people with hepatitis, and is simply a reaction to criticism the network received after actor Larry Hagman and the late Mickey Mantle both got livers").
behaviors. This includes raising insurance premiums and altering pre-existing insurance plans. Insurance companies cover the majority of health care in the United States. The bulk of the population has health insurance through a group plan supplied by their employer. Employer health plans are usually either commercial insurance carriers or self-insured plans. For a commercial insurance carrier, the private insurance company itself assumes part or all of the financial risks for the company’s employees’ health. For self-insured plans, the employer assumes all of the financial risks and responsibility.

In all types of insurance plans, underwriting is used as a way of "classifying people according to risk." "The social purpose of health insurance is to spread risk across groups, enabling wider access to services." There are three separate types of underwriting: the individual, the experience-rated, and the community-rated. The individual type of underwriting assesses one person’s risk and premium. The experience-rated underwriting applies to a group and is based on the previous risk to the entire group. The community-rated underwriting addresses a geographic region’s expected risk and loss. Employers traditionally utilized the second type of underwriting.

47Veatch, Voluntary Risks, supra note 14, at 508.
48Id. Note that taxing will not be dealt with because taxing is beyond the scope of this paper.
49See M. Susan Ridgely & Howard H. Goldman, Putting the "Failure" of National Health Care Reform in Perspective: Mental Health Benefits and the "Benefit" of Incrementalism, 40 St. Louis U. L.J. 407, 432 (1996) (discussing that "[a]pproximately 75 percent of insurance coverage is provided through employers and is paid for by employers and their employees, with public subsidization through a tax exemption for the employer").
50Ostrer, supra note 25, at 568.
52Id.
53Gostin, Securing Health, supra note 2, at 38.
54Id. See John V. Jacobi, The Ends of Health Insurance, 30 U.C. Davis L. Rev. 311, 311 (1997) (expressing that "[h]ealth insurance is premised, in part, on notion of mutual aid and social pooling -- the common effort to ameliorate each person’s risk of catastrophic medical expense").
55Ostrer, supra note 25, at 566.
56Id.
57Id.
58Id.
Insurance companies are able to utilize an individual's health hazardous behavior, usually smoking, to raise insurance premiums. However, most types of health insurance are sold to groups; therefore, basing premiums on the individual's health hazardous behavior is difficult. In fact, Bierer and Rigotti point out that "[h]ealth maintenance organizations must set rates based on community experience and must petition the Federal Government to use smoking as a criterion for modification rates. Only about fifteen percent of health insurers selling individual policies offer discounts to non-smokers, and the average discount is about ten percent." While only fifteen percent of all individual policies take into account whether an individual smokes, this type of penalty is exactly the sort of action that has previously been suggested.

Even though in some instances the Federal Government becomes involved in insurance regulation, state guidelines and statutes regulate the majority of the insurance industry. Only a few federal laws apply to insurance regulation because the legislature intended for the states to monitor this realm. The insurance laws, of course, can vary from state to state; generally, most states utilize regulation in order to protect customers and maintain the solvency of insurance companies. Notwithstanding states' guidelines, there is a loophole in the system that many companies take advantage of in order to bypass certain state laws.

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59Bierer, supra note 14, at 523. See Ostrer, supra note 25, at 567-70 (discussing that life insurers offer preferred-risk premiums to individuals who avoid unhealthy behaviors, such as tobacco use or substance abuse and that saliva tests can be used to detect smoking status).

61Bierer, supra note 14, at 525 (discussing the difference of the health insurance market versus life insurance. "Most private health insurance is sold to groups, not individuals, which makes it logistically difficult to offer different rates based on individual behavior").

63Veatch, Voluntary Risks, supra note 14, at 507-08.

65Id.

67See Maria O'Brien Hylton, Insurance Classifications After McGann: Risk Efficiently in the Shadow of the ADA, 47 BAYLOR L. REV. 59, 77-78 (1995) (noting that "ERISA is a particularly attractive option because ERISA plans are not subject to state insurance mandates").
The Employee Retirement Income Security Act of 1974 (ERISA) creates a loophole by preempting all state regulations of the employer self-insured insurance plans. This is problematic because most guidelines to safeguard the employee are mandated by state regulation. In 1985, the Supreme Court held that ERISA pre-empts state laws. Not surprisingly, there has been a vast shift from commercial carrier insurance to self-insured plans; specifically there was a twenty percent increase from 1982 to 1986.

The self-funded plans have allowed companies to underwrite limitations on coverage for human immunodeficiency virus (HIV)-positive individuals, which may not be allowable under state law. However, due to the ERISA preemption, the afflicted individuals cannot seek protection under the aegis of the state’s law. The case of McGann v. H & H Music Company exemplifies this problem. The loophole in

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69 See Ridgely, supra note 49, at 433-34 (discussing how state mandates are less effective because such a large percentage of employers are self-insured and how there is also “significant concern that without Congressional action on ERISA, state experimentation with large scale health care reform within their states will be limited, because ERISA hinders state governments’ ability to regulate all employers, especially the large employers”).
70 See Sohlgren, supra note 51, at 1267 (“In its first direct affirmation of the distinction between self-insured and insured employee benefit plans, the Court held that the deemer clause exempts self-insured ERISA plans from state regulation relating to such plans”) (citing FMC Corp v. Holliday, 111 S. Ct. 403 (1990)).
72 Hylton, supra note 67, at 79.
73 Sohlgren, supra note 51, at 1251.
75 Id. at 403-05. See Hylton, supra note 67, at 61 (“John McGann’s story is a straightforward one. In 1982 he began working for H & H Music Company and was covered by the company’s group medical care plan. Pursuant to the plan, in effect from August 1, 1987 to July 31, 1988, all listed coverages were fully insured, up to a lifetime maximum of $1 million. In December 1987 McGann was diagnosed with AIDS. In March 1988, he met with company officials and discussed his illness. Four months later, all employees were notified that the medical care plan was terminated effective August 1, 1988, and that a new group medical/hospitalization plan would become effective and would limit benefits payable for AIDS-related conditions to a
the legal system allowed for an alteration of McGann's health care policy and the United States Court of Appeals Fifth Circuit found that such a modification was legal. The court held that:

[section 510 does not mandate that if some, or most, or virtually all catastrophic illnesses are covered, [acquired immune deficiency] AIDS (or any other particular catastrophic illness) must be among them. It does not prohibit an employer from electing not to cover or continue to cover AIDS, while covering or continuing to cover other catastrophic illnesses, even though the employer's decision in this respect may stem from some 'prejudice' against AIDS or its victims generally.]

In 1992, the Supreme Court denied certiorari and the McGann decision stands as decided by the Fifth Circuit court. While McGann was not specifically denied coverage because of a health hazardous behavior, this case serves as an example of a stigmatized disease being denied coverage. It is recognized in McGann that the self-funded plan was not necessarily separating the individual based on health hazardous behaviors, because individuals who contracted HIV from unprotected sex as opposed to a blood transfusion would all be treated equally. Notwithstanding, it is important to note that other non-stigmatized diseases and other catastrophic illnesses that result in high lifetime maximum of $5,000. No limitation was placed on any other catastrophic illness. Like many employers hoping to cut health insurance costs, H & H elected to self-insure under the new plan."

76McGann, 946 F.2d at 408.
77Id. at 404-05. See also Hylton, supra note 67, at 62 (discussing the Fifth Circuit's decision to affirm the "district court's grant of summary judgment in the employer's favor on the ground that the changes McGann complained of were motivated by a desire to 'avoid the expense of paying for AIDS treatment.' Because the reduction in AIDS coverage affected all employees and because there was no evidence that H & H ever promised the $1 million cap would be permanent, the court of appeals concluded the McGann could not demonstrate either that he was entitled to the higher cap or that he was the victim of personal retaliation").
79Palmer, supra note 68, at 1351.
80Hylton, supra note 67, at 66.
81Which may be a health hazardous behavior depending on the situation.
treatment costs (for instance, organ transplantation) were not limited.\textsuperscript{82} It was the stigmatized disease that has historically been associated with "sinful" behavior that was selectively punished.\textsuperscript{83} This case and other employer caps on insurance do show a selective "singling out" of individuals with HIV.\textsuperscript{84} Such segregation is exemplified by suggestions to protect only those who "innocently" contracted HIV as opposed to those who are deemed "guilty" for contracting HIV through intravenous (IV) drug abuse or homosexual activity.\textsuperscript{85} If the issue was strictly cost containment, then other costly illnesses and procedures would have been similarly restricted like McGann's policy. If individuals who partake in "voluntary" injurious behaviors become stigmatized as undeserving of health care or deserving of bearing the burden of costs, it is feasible that the employer of the self-funded plan may utilize this same loophole against other diseases related to hazardous behaviors to further enhance cost containment.

**ANALYSIS**

The first step to implement proposals to find individuals responsible for health hazardous behaviors is to assign culpability.\textsuperscript{86} Culpability means that the product of the health hazardous behaviors is the fault of the

\textsuperscript{82}McGann, 946 F.2d at 403.

\textsuperscript{83}See Michelle Oberman, Test Wars: Mandatory HIV Testing, Women, and Their Children, 3 U. CHI. L. SCH. ROUNDTABLE 615, 619 (1996) (discussing "it was inevitable that society would respond to the fearsome HIV epidemic by distinguishing the 'innocent' from the 'guilty' victims"). See also Arthur S. Leonard, Ethical Challenges of HIV Infection In The Workplace, 5 NOTRE DAME J.L. ETHICS & PUB. POL’Y 53, 71 (1990) (explaining that "employers have justified HIV exclusions as a 'self-inflicted problem' because of its association with IV drug use or promiscuous sexual behavior").

\textsuperscript{84}See Leonard, supra note 83, at 70-71 (explaining that "[h]ealth benefit expenses related to HIV infection are not necessarily greater than those related to other life-threatening illnesses normally covered without question by health plans, so singling out HIV infection but not other conditions for exclusions or caps does not have an objective justification").

\textsuperscript{85}See id. at n.68 (describing U.S. Representative William Dannemeyer's proposal to eliminate "protection for people with infectious disease"; however, exempting those who "innocently" contracted HIV).

\textsuperscript{86}See Dworkin, supra note 14, at 30 ("To make a claim about the culpability of individuals for their poor health status claims three things: that the individual was in some way at fault in behavior; that the faulty behavior produced the lowered health status; that the faultiness of the behavior created the damage to health"). See also Louis W. Sullivan, M.D., Healthy People 2000, 323 NEW ENG. J. MED. 1065, 1066 (1990) (explaining that "[b]etter control of fewer than ten risk factors... could prevent between 40 and 70 percent of all premature deaths, one-third of all cases of acute disability, and two-thirds of all cases of chronic disability").
individual.87 Under culpability there are two major questions—"is there any relationship between lifestyle and disease?" and "are health hazardous behaviors voluntary?"

Culpability

Is there a relationship between lifestyle and disease?

Undoubtedly, there is strong support for the idea that behaviors and lifestyles impact health.88 Statistical correlations declare that there is an increased probability for disease related to some behaviors.89 For instance, smoking is definitely correlated to a "substantial reduction in life expectancy" and associated with specific diseases such as, emphysema, cancer, and coronary artery disease.90 In 1967, a study examining correlates of death revealed that sixty-seven percent of deaths were "due to diseases known to be caused or exacerbated by alcohol, tobacco smoking or overeating, or were due to accidents."91 Statistics in 1989 comparing smoking to both AIDS and drug abuse revealed smoking caused 350,000 deaths per year, while AIDS and drug abuse caused 60,000 and 10,000 deaths respectively.92 Furthermore, there are known high-risk behaviors that are linked to the exposure and contraction of HIV.93 Lester Breslow conducted a famous study that examined seven different personal habits of individuals and correlated them with poor health, disease, and mortality. He found:

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87Dworkin, supra note 14, at 28.
89See Schwartz, supra note 9, at 206 (discussing general risks from behavior, but a direct link is difficult to establish).
91Robert M. Sade, M.D., Medical Care As a Right: A Refutation, 285 NEW ENG. J. MED. 1288, 1291 (1971).
At every age from twenty to seventy, persons in a representative sample of the adult population who followed all seven of these habits -- eating moderately, eating regularly, eating breakfast, no cigarette smoking, moderate or no use of alcohol, at least moderate exercise, and seven to eighty hours of sleep -- had better health status than those who followed six. Those who followed six of the habits enjoyed better health status than those who followed five; five better than four; four better than three . . . . The average physical health of those seventy years of age who reported all of the good health practices was about the same as those thirty-five to forty-four who reported fewer than three.94

These statistics are just a few examples extracted from a substantial amount of literature that cites correlations between disease and lifestyle.95 It would be grossly inaccurate to deny that connections between health behaviors and disease exist. Notwithstanding the connection, the information becomes problematic when one tries to reduce the statistics of a group to represent the idiographic case. The fact is that there is an increased probability of disease, but not necessarily an absolute cause-

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94Breslow, supra note 88, at 450.
95See Arthur J. Barsky, M.D., The Paradox of Health, 318 NEW ENG. J. MED. 414, 415 (1988) (describing gains in combating cardiac disease as attributed to life-style changes); David S. Bloch & William Robert Nelson Jr., Defining "Health": Three Visions and Their Ramifications, 1 DEPAUL J. HEALTH CARE L. 723, 724 (1997) (discussing how "m[any choices, including organ donation, choice of diet, and money spent on risky athletic pursuits, impact a person's health"); Nedra B. Belloc, Relationship of Health Practices and Mortality, 2 PREVENTIVE MED. 67, 79-80 (1973) (reporting the results of a study, which show that "for the older age groups there was a striking inverse correlation between the number of health practices and the mortality level"); Deborah A. Stone, The Resistible Rise of Preventive Medicine, 11 J. HEALTH POL'Y & L. 671, 675 (1986) (describing "elimination of smoking, reduction of alcohol misuse, dietary changes, exercise, periodic screening for cancer and high blood pressure, and adherence to speed laws and use of seat belts" as a mode of promoting health through prevention) (citing DEP'T OF HEW HEALTHY PEOPLE: THE SURGEON GENERAL'S REPORT ON HEALTH PROMOTION AND DISEASE PREVENTION, DHEW Pub. No. 79-55071 (1979)); OncoLink Cancer News (visited Feb. 19, 1999) <http://oncolink.upenn.edu/cancer-newsreuters/1999/feb/c102189p.html> (discussing that "eating tomatoes and tomato-based products is associated with a reduced risk of developing a variety of cancers"); OncoLink Cancer News (visited Feb. 19, 1999) <http://oncolink.upenn.edu/cancer-newsreuters/1999/feb/md02189a.html> (discussing that "[t]he overall advice is don't rush to change your lifestyle on the basis of any scientific report . . . . It's far better to adopt a skeptical view, to wait for a large body of evidence to emerge and then, if it seems warranted to you, to change your behavior").
effect relationship. This is illustrated by the fact the not all smokers get cancer, and not all cancer victims smoke. There is a connection between lifestyles and disease, but the correlation is based on statistical probabilities.

*Are health related lifestyles and behaviors voluntary?*

The term “responsible,” as it infers to a general relationship between behavior and disease, based on statistical probabilities, is an accurate and justified statement. However, the proposals for finding an individual responsible for disease do not simply imply a correlation. The suggestions are utilized to encompass more than just a connection; they infer that the individual is at fault for the disease. Under the aegis of such proposals, the individual’s actions are rendered voluntary and the person is blamed for the associated negative results.

In order to validate assigning responsibility to the individual, it must be established that the individual could have avoided the hazardous behavior. Avoidability rests on the notion that there was an absence of compulsion, namely that the individual could have acted otherwise. The notion that the individual has voluntarily chosen the avoidable health-risky behavior is pivotal to assigning fault. One could not rationally punish a person who is viewed as lacking the option to do otherwise.

There are two sides of the debate focusing on the voluntariness of health behaviors, non-voluntary and voluntary. The claim that health behaviors are non-voluntary is based on theories of hard determinism and

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96 See Schwartz, supra note 9, at 205-06 (clarifying that “[w]hile we know of the connection between lack of exercise and heart disease, we also know that hundreds of thousands of physically fit people die of heart disease each year while hundreds of thousands of the unfit live”).

97 Id.

98 See Dworkin, supra note 14, at 28 (“It is to claim that certain judgments or actions are warranted as a response to some faulty aspect of the person’s conduct . . . . In the case of legal liability it will usually be some punishment or civil liability. With respect to moral responsibility it will usually be some judgment of wrong-doing or some form of blame, or some duty to make amends or compensate for injury”).

99 Id. See Veatch, Voluntary Risks, supra note 14, at 507 (implying that an individual is to blame for disease not just that a simple correlation exists).

100 Dworkin, supra note 14, at 30.

101 See JOEL FEINBERG, REASON & RESPONSIBILITY 411 (1996) [hereinafter FEINBERG, RESPONSIBILITY] (discussing that “avoidability is a necessary condition of responsibility . . . . Most of us would agree, my ability to do otherwise is a necessary condition of praise or blame, reward or punishment, in short, for my being responsible”).

102 Id.
indeterminism. The first non-voluntary theory, hard determinism, suggests that all actions that occur are not caused by the individual and will necessarily occur. Under the auspices of such a theory, the path of an individual’s life is not chosen, rather it is predetermined and uncontrollable. This theory does not find that the individual is responsible for their life path or the consequences. Determinism extinguishes the individual’s responsibility for health-related disease. For instance, alcoholism has been touted as genetically inherited, and therefore, deemed uncontrollable by the individual. In addition, health damaging behaviors, such as smoking, have also been explained as psychologically determined. Similar to genetic determinism, psychological determinism absolves the health perpetrator of responsibility for her illness. Notwithstanding these arguments that support behavior as determined, the arguments are flawed because genetic and psychological determinism does not account for the “triggers” and other associated variables that contribute to the manifestation and cessation of health hazardous lifestyles. For instance, saying that an individual is “genetically determined” to be an alcoholic does not account for the ability of an alcoholic to quit drinking. If the alcoholic is truly

Id. at 410-17. See also A.J. Ayer, Freedom and Necessity, in REASON AND RESPONSIBILITY 431, 431 (Joel Feinberg ed., 9th ed. 1996) (explaining that “[w]hen I am said to have done something of my own free will it is implied that I could have acted otherwise; and it is only when it is believed that I could have acted otherwise that I am held to be morally responsible for what I have done”).

FEINBERG, RESPONSIBILITY, supra note 101, at 410.

Id. See also Paul Holbach, The Illusion of Free Will, in REASON AND RESPONSIBILITY 418, 419 (Joel Feinberg ed., 9th ed. 1996) (discussing hard determinism he notes “[t]he motives that determine the voluptuary and the debauchee to risk their health, are as powerful, and their actions are as necessary, as those which decide the wise man to manage his”).


Veatch, Voluntary Risks, supra note 14, at 510 (explaining that “the argument is not normally based on organic or genetic theories of determinism, but on more psychological theories. [For instance,] the smoker’s personality and even the initial pattern of smoking are developed at such an early point in life that they could be viewed as beyond voluntary control. If the smoker’s behavior is the result of toilet training rather than rational decision making, then to blame the smoker for the toilet training seems odd . . . . Compulsive eating, the sedentary life-style, and the choice of a high-stress patterns may all be psychologically determined”).

Id.
genetically determined, then she would lack the capacity to act in a different manner.\textsuperscript{110}

The second non-voluntary theory, indeterminism, suggests that actions happen randomly by chance.\textsuperscript{111} The individual cannot control what happens, because everything is a fortuitous event.\textsuperscript{112} Individuals who contract a major illness are observed as unfortunate, not necessarily deserving due to behavior and lifestyle choices. Historically, disease has been considered the cause of pathogens, "entities, things that invade and are localized in part of the body."\textsuperscript{113} Illness has been considered a type of deviance\textsuperscript{114} and disease considered an uncontrollable state that removes the individual's responsibility.\textsuperscript{115} Under the aegis of this theory, health hazardous behaviors are not viewed as the cause of disease. Rather the cause stems from the pathogen that randomly attacks the individual's health. Indeterminism, like determinism, is flawed. Indeterminism describes disease as a random occurrence caused by pathogens, which does not account for the vast literature which links lifestyle to disease.\textsuperscript{116} Both non-voluntary theories—determinism and indeterminism—oversimplify health behaviors by purporting that disease is completely unrelated to any human choice. In addition, these theories are contrary to the general notion of individualism on which society is built.\textsuperscript{117}

The other side of the debate focuses on behaviors as voluntary. The two theories supporting this standpoint are libertarianism and soft determinism.\textsuperscript{118} Libertarianism pronounces that the person has free will and voluntarily chooses her action.\textsuperscript{119} This theory purports that human

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\textsuperscript{110}Feinberg, Responsibility, supra note 101, at 410.
\textsuperscript{111}Id. at 412.
\textsuperscript{112}Id.
\textsuperscript{114}Eric Friedson, Profession of Medicine: A Study of the Sociology of Applied Knowledge 226 (1970) (describing that "the term 'illness,' when used to give meaning to perceived deviance, implies that what is thought to be deviant does not arise through the deliberate, knowing choice of the actor and that it is essentially beyond his own control").
\textsuperscript{115}Id.
\textsuperscript{116}Breslow, supra note 88, at 450.
\textsuperscript{117}See Veatch, Medical Model, supra note 106, at 66 (discussing that these views oppose the foundations of liberalism, which is problematic when contemplating basing health care policies on such theories because of the theories' extreme commitment to non-voluntarism in a society so heavily imbued with individualism).
\textsuperscript{118}Feinberg, Responsibility, supra note 101, at 413-15.
\textsuperscript{119}Id. at 413.
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actions are subject to reasoning and are absolutely undetermined.120 Lifestyle choices are viewed as freely chosen with the option of choosing otherwise and not necessarily related to other factors. In order to justify adopting the different proposals of individual culpability, one would have to embrace this theory of behavior. In fact, the tobacco companies have used this theory to defend against product liability claims.121 However, this model is problematic because it does not account for the influence of social factors. This theory reduces health behaviors to purely voluntary choices, thereby excluding any other contributing factors—like environment, genetics, education, and socio-economic status.

The second voluntary theory, soft determinism, is the combination of determinism and libertarianism. It posits that determinism is true, but that it is also congruous with free will and responsibility.122 This notion of being determined and still having free will seems incommensurable, but the two can co-exist.123 The term determinism connotes a factual correlation, not necessarily the individual’s powerlessness.124 The actions are determined because they can be explained. The individual, however, is free to choose whether or not to act.125 Three factors identify whether an individual was free to act other than they way she did. A.J. Ayer explains these factors as follows:

[T]o say that I could have acted otherwise is to say, first, that I should have acted otherwise if I had so chosen; secondly, that my action was voluntary in the sense in which the actions, say, of the kleptomaniac are not; and thirdly, that nobody compelled me to choose as I did: and these three conditions may very well be fulfilled. When they are fulfilled, I may be said to have acted

120Id.
121See Robert E. Goodin, *The Ethics of Smoking*, 99 ETHICS 574, 579 (1989) (describing that “[c]ourts have been as sensitive to this distinction [the voluntariness of action] as moral philosophers, appealing to the venerable legal maxim, *volenti non fit injuria*, to hold that through their voluntary assumption of the risk smokers have waived any claims against cigarette manufactures”). Note, however, that the state cannot argue that both the individual and the tobacco companies are both liable—these two suggestions together are incommensurable.
122FEINBERG, RESPONSIBILITY, supra note 101, at 413.
123Ayer, supra note 103, at 434-35.
124Id. at 435.
125Id. at 436.
freely . . . . And that my actions should be capable of being explained is all that is required by the postulate of determinism.\textsuperscript{120}

The difference between soft and hard determinism resides in the capacity of the individual “to do otherwise.”\textsuperscript{127} Even if the individual’s action is causally determined, this does not obviate the individual from avoiding the action. Soft determinism most closely resembles the complexity of health related behaviors. While most individuals are “free” to choose otherwise, there are many associated factors that causally determine the lifestyle choice.\textsuperscript{128} For instance, a person who is addicted to smoking is “free to choose otherwise”; however, often the physiological need or addiction precludes the individual from quitting.\textsuperscript{129} In this sense, the smoker is causally determined. What impairs the argument that the addiction absolutely determines the action, like the hard deterministic theory, is the fact that individuals freely decide to quit smoking and succeed.\textsuperscript{130} Notwithstanding, the fact remains that it is immensely difficult for an individual to overcome this physiological barrier and choose to act otherwise.\textsuperscript{131} Admittedly, addiction has powerful effects on the behavior of an individual. Nonetheless, this does not relegate the individual to a position of a “helpless prisoner of fate.”\textsuperscript{132}

Similarly, strong correlations exist between socio-economic class and health related behaviors.\textsuperscript{133} In fact, discussion of these correlations

\begin{thebibliography}{10}
\bibitem{120} Id. at 435. \textit{See FEINBERG, RESPONSIBILITY, supra note 101, at 413} (explaining Ayer’s point of view Feinberg notes “according to this theory [soft determinism], if I can do what I choose, I am free in only the sense of free used in ordinary parlance and in ascriptions of responsibility, and it matters not whether my choice itself was causally determined”).
\bibitem{127} FEINBERG, RESPONSIBILITY, \textit{supra} note 101, at 414.
\bibitem{128} Ayer, \textit{supra} note 103, at 435 (explaining that “[I]t may be said that my childhood experience, together with certain other events, necessitates my behaving as I do. But all that this involves is that it is found to be true in general that when people have had certain experiences as children, they subsequently behave in certain specifiable ways; and my case is just another instance of this general law. It is in this way indeed that my behaviour is explained. But from the fact that my behaviour is capable of being explained, in the sense that it can be subsumed under some natural law, it does not follow that I am acting under constraint”).
\bibitem{129} Goodin, \textit{supra} note 121, at 584.
\bibitem{130} \textit{Id.}
\bibitem{132} Ayer, \textit{supra} note 103, at 436.
\bibitem{133} Paula M. Lantz, Ph.D., et al., \textit{Socioeconomic Factors, Health Behaviors, and Mortality: Results From a Nationally Representative Prospective Study of U.S. Adults}, 279 JAMA 1703, 1703 (1998).
\end{thebibliography}
suggest that finding the individual responsible for disease distorts the astronomical contribution socioeconomic status has on disease. Even if an individual is "free" to choose lifestyle behaviors, the influence of an individual's social circumstances may causally determine the health behavior. There have been numerous studies that reveal a strong correlation between disease and socioeconomic status. Socioeconomic status is linked directly to higher rates of contracting HIV. Furthermore, non-smokers are more likely than smokers to have greater than a high school education. These citations represent a few select examples of the implications social structure plays in determining health related lifestyles. Notwithstanding, the literature does not negate the fact that some individuals, against the odds, are able to overcome the barriers. Nonetheless, the fact remains that the

134 Veatch, Voluntary Risks, supra note 14, at 510.
135 See Barbara Starfield, M.D., MPH, Child Health Care and Social Factors: Poverty, Class, Race, 65 BULL. N.Y. ACAD. MED. 299, 304 (1989) (discussing the correlation between socioeconomics and disease and noting "there is certainly less evidence for the harmful effects of cholesterol than there is for the harmful effects of poverty with its relative risks of two to four. . . . Illness is a function of predisposing and modifying external forces and host factors. Social conditions such as low income act through heightened exposure to adverse environmental conditions, [and] through induced behaviors related to living in deprived circumstances (such as the inability to afford adequate diets) . . . . Genetic substrate is explicitly recognized as a factor, of course, but its expression is modified by other coexisting influences"). See also Patrick W. Conover, Social Class and Chronic Illness, 3 INT'L J. HEALTH 357, 366 (1973) (discussing low socioeconomic status and disease). See also CASSELL, supra note 113, at 14 (explaining that "[i]f the poor have more sickness than the comfortable, if their illnesses are more severe—both well-known phenomena—then the social setting in which disease occurs must influence its origins, course, and treatment"). See also MARY MAHOWALD, WOMEN AND CHILDREN IN HEALTH CARE: AN UNEQUAL MAJOIRTY 220 (1993) (noting that "[s]ocial problems such as unemployment, underemployment, poor nutrition, teenage pregnancy, drug use, and prostitution all contribute mightily to the health deficit of the poor").
136 See Theresa Diaz et al., Socioeconomic Differences Among People with AIDS: Results from a Multistate Surveillance Project, 10 AM. J. PREVENTIVE MED. 217, 217 (1994) (describing that "[s]ocioeconomic status is an important correlate of behaviors that affect health, health service access and use, the risk of disease, the risk of an adverse outcome once disease occurs, and mortality").
137 See Manning, supra note 14, at 1604 ("[A]ccording to the 1983 National Health Interview Survey (NHIS), those who never smoke are 1.5 time more likely than current smokers to have more than a high school education"). See Goodin, supra note 121, at 615 (discussing that smoking is known to correlate "strongly with race and class").
138 See Veatch, Voluntary Risks, supra note 14, at 511 (admitting that "there are disease and health differentials even within socioeconomic classes and that some element of voluntary choice of life-style remains that leads to illness").
vast majority of people cannot prevail over such adversity regardless of whether they have the "freedom" to do so.\textsuperscript{139}

Technically many lifestyle choices are considered voluntary because the person is ultimately free to act otherwise. However, it is exceedingly apparent from the literature cited that choosing to engage in health hazardous behaviors is not so simplistic. Referring to health hazardous behaviors as purely voluntary does not appropriately acknowledge the plethora of factors that are shown to be causally linked to health behavior. Sifting out all of the various connectors of health hazardous behaviors is an arduous task, but clearly these associated factors refute the simplistic notion of voluntarism.

Despite the justifiable correlation between lifestyle and disease, the next step of accepting voluntarism, which appoints blame for disease, is refutable. Notwithstanding, even if one accepts that health behavior is strictly voluntary this admission only establishes culpability. Therefore, liability must also be justified prior to execution of the proposals.

**Liability**

Once an individual is deemed culpable, the next step is to establish liability, namely "that certain consequences do, or ought to flow from this first judgment."\textsuperscript{140} Under the liability prong, there needs to be justification for adopting proposals that penalize individuals for engaging in behaviors that hurt their health: the six possible justifications are deterrence,\textsuperscript{141} punishment,\textsuperscript{142} fair distribution of burdens,\textsuperscript{143} social utility,\textsuperscript{144} paternalism,\textsuperscript{145} and harm principle.\textsuperscript{146}

**Deterrence**

One justification for imposing some penalty for a health hazardous lifestyle is that it will deter the unhealthy behavior. Generally this theory

\textsuperscript{139}Id.

\textsuperscript{140}Dworkin, supra note 14, at 28.

\textsuperscript{141}Schwartz, supra note 9, at 207-09.

\textsuperscript{142}Id. at 209-12.

\textsuperscript{143}Schwartz, supra note 9, at 212-16; Wikler, supra note 39, at 232.

\textsuperscript{144}Wikler, supra note 39, at 234.

\textsuperscript{145}Joel Feinberg, Legal Paternalism, 1 CAN. J. PHIL. 105, 105 (1971) [hereinafter Feinberg, Paternalism].

\textsuperscript{146}Dan E. Beauchamp, Ph.D., Community: The Neglected Tradition of Public Health, 1985 HASTINGS CTR. REP. 28, 29 [hereinafter Beauchamp, Community].
posits that "an individual will engage in proscribed conduct as long as the ‘perception of the possibility that he . . . will suffer a sanction’ is less than the ‘expected private benefit’ provided by that conduct." However, deterrence is not a good justification because it does not tend to work. “Lost health care coverage simply comes too late to be an effective deterrent, and, as a general matter, its consequences are too insignificant to add anything to the incentive of good health itself.” For instance, the deterrence theory does not work for IV drug users. Not only were needle exchange programs not found to increase use, but other studies for addicts found that the hazardous behavior is not deterred by undesirable consequences. In fact, some proponents of the needle exchange program argue that promotion of total health sometimes means accepting the health hazardous behaviors. For IV drug abusers, not only does the lack of clean needles not deter the behavior, but denial of clean needles is not more cost effective than supplying clean needles. Furthermore,

148Id. at 208. See Anne R. Somers & Mary C. Hayden, Rights And Responsibilities In Prevention, 9 HEALTH EDUC. 37, 38 (1978) (suggesting that “[i]t is futile to try to get individuals to adopt a healthier lifestyle; societal pressures are too great in the other direction”).
149Schwartz, supra note 9, at 207.
150See Erik Grant Luna, Our Vietnam: The Prohibition Apocalypse, 46 DEPAUL L. REV 483, 540 (1997) (discussing that “needle exchange program and general availability of syringes does not inspire drug use”).
151See Cloud, supra note 147, at 767 (discussing that “[m]edical theory and clinical experience suggest that addicts will pursue and consume cocaine regardless of disastrous financial consequences, as long as supplies remain available. A growing body of information indicates that cocaine addicts will got to extremes to finance their addictive behaviors”).
152See Gostin, HIV, supra note 93, at 59 (explaining that sometimes “[t]he most important characteristic of the physician-patient relationship is the physician using [his or her] best efforts and expertise to promote the patient’s total health.” Suggesting that giving the needles for the drug users is promoting the patient’s total health by preventing transmission of disease).
153See Luna, supra note 150, at 524 (noting that “medical treatment and prevention are much more economically efficient than criminalization; money spent on treatment is seven times more likely to stem drug addiction than imprisonment. Further, while it costs a city about $160,000 to run a needle-exchange program, one syringe-infected AIDS victim will require upwards of $120,000 per year in public assistance. By preventing only two drug users from contracting HIV, a needle-exchange program more than covers its costs.”) (citing THE WAR ON DRUGS IS LOST, NAT’L REV., Feb. 12, 1996, at 34 (editorial of William F. Buckley), THE WAR ON DRUGS IS LOST, NAT’L REV., Feb. 12, 1996, at 37 (editorial of Kurt Schmoke)).
deterrence does not work because often the health hazardous behavior is valued more than the consequences that serve as the deterrent.  

**Punishment**

The idea of punishment stems from the notion that these behaviors are voluntary and deserve penalty for this "free choice." Therefore, choosing to punish individuals who partake in hazardous lifestyles would be based on the same justifications as for those individuals who commit crimes. When a crime is committed the perpetrator loses some rights. However, there are some rights that are fundamental, like the right to trial. Therefore, these basic rights are not relinquished regardless of the individual's action. Society must question if health care, like the right to trial, is a basic right that cannot be relinquished.

If society determines that there is no basic right to health care, then guidelines must be implemented to "police" the health hazardous lifestyles. These policing guidelines will be difficult to draft for several reasons. First, the physician-patient relationship would be seriously compromised if the health care worker was expected to act as a guard of lifestyle behaviors. Second, many lifestyle behaviors are strictly private and could not be easily monitored, for example sexual activity. Third,

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154 See Cloud, supra note 147, at 770 (explaining that "[i]f addicts do engage in rational [utility-maximizing] decision making, then they are likely to attribute so much value to consuming cocaine that the perceived costs will be outweighed by the benefits of consumption").


156 See Dworkin, supra note 14, at 31 (discussing that "the jump from culpability to liability in the area of voluntary health risks will be very much like the one in the area of criminal punishment. Basic considerations of justice will show that it is not unfair to treat certain individuals more harshly than others, and the role of choice will be essential to showing this").

157 See Rajendra Persaud, Smokers' Right To Health Care, 21 J. MED. ETHICS 281, 283 (1995) (explaining that "we readily accept that while everyone has a right to liberty, that right is lost in committing a serious crime").

158 See id. (suggesting that "however heinous the crime, criminals have a right to trial, and to certain basic conditions in prison. Might not health be considered such a basic right?").

159 Id.

because a lifestyle is easy to monitor\textsuperscript{161} does not make it the only suspect behavior. Just as all crimes are illegal so should all hazardous lifestyles be deemed punishable, not just the ones that are easy to monitor and catch. For instance, smoking is notoriously considered deserving of penalty and tends to be easier to monitor than most behaviors; notwithstanding, all hazardous health behaviors should be equally punished.

\textit{Fair Distribution of Burdens}

The third justification is based on the notion that it is socially just to equitably distribute the burdens of costs and resources based on each individual’s lifestyle.\textsuperscript{162} The individuals who create the costs from health hazardous lifestyles proportionately receive burdens based on this choice.\textsuperscript{163} This justification assumes that there are substantial differences in the costs of care for those engaging in unhealthy lifestyles and those abstaining from unhealthy lifestyles. This assumption, however, is not necessarily true.\textsuperscript{164} Others suggest that if the objective is to save money,
then the health perpetrators should be encouraged to smoke because “smoking tends to cause few problems during a person's productive years, and then kills them before social security and pension payments are made.” In addition, the question arises whether it is socially just to only select some hazardous lifestyles and not all hazardous behaviors. However, if all hazardous lifestyles were chosen, then most people would be considered health perpetrators.

**Social Utility**

The fourth justification - social utility - is based on the overall benefit to society, which is the consequence from a cessation of self-destructive practices. The benefit to society is based on economics. This justification takes into consideration the direct costs of health care and indirect costs of illness, such as sick days from work, and unfulfilled responsibilities to family. The social utility argument saves money at the cost of the health perpetrator's liberty. The question that flows from the social utility argument is what other personal decisions affect an individual's health. "Decisions about family planning, choice of career, type of home cuisine, and where to spend vacations have sizable effects upon health, and the argument from utility applies equally well to them." The social utility argument focuses on economics and because

culprit that increases medical costs). See also Leichter, supra note 164, at 33 (noting that “[i]n 1975 the costs of smoking-related illnesses alone were said to account for about 10 percent of the $122 billion U.S. health bill”).


See Leonard, supra note 83, at 71 (expressing that “[e]ven if one were to grant employers the right to allocate health care benefits based on their normative evaluation of the conduct which led to infection [HIV], one would question why HIV-related claims should be excluded while illnesses arising from other behaviors, such as smoking, drinking, or poor dietary habits, were not similarly treated. Exclusion of some “lifestyle” claims but not others seems based arbitrarily on employer dislike or disapproval of the people involved, and violates the justice principle by discriminating in compensation, since some employees would be covered for their “lifestyle” illnesses and others would not, regardless of their contribution to workplace productivity”).

Wikler, supra note 39, at 234.

See id. (suggesting that “[i]t is enough for the utilitarian that health promotion provides society with an opportunity to enjoy significant economic gain and to avoid loss”).

Id.


Wikler, supra note 39, at 235.

Id.
of this focus, other liberty choices could equally apply to the goal of societal economic gain.\textsuperscript{173} If the social utility argument applies to non-health related behaviors, then the justification for penalizing only the health hazardous lifestyles fails.

\textbf{Paternalism}

The fifth justification, paternalism, is the liberty limiting principle established to protect the individual from herself.\textsuperscript{174} For instance, proponents of this principle assert that smoking is linked to disease, and thereby, causes harm to the individual.\textsuperscript{175} This claim is not entirely correct. The only verified harm to oneself is an increased probability to disease, not that harm will definitely occur.

John Stuart Mill, probably the most famous adversary of paternalism, adamantly opposed such restrictions on an individual’s liberty: “[b]ut neither one person, nor any number of persons, is warranted in saying to another human creature of ripe years, that he shall not do with his life for his own benefit what he chooses to do with it.”\textsuperscript{176} Furthermore, Mill purported that it is more likely that the government would be mistaken about what is best for the individual than she would.\textsuperscript{177} The fact that the individual is “most interested in his [her] own well-being,” makes it more probable that the individual will do a better job at deciding what is in her

\textsuperscript{173}See \textit{id.} at 235-36 (“We will be in a better position to see if the utilitarian argument stands on its own if we focus on behaviors which are neutral with respect to these extraneous attitudes . . . . The utilitarian argument, we must recall, targets these decisions for change not primarily because of their effects on health, but because of the effects of ill health on the economy and the public welfare generally. The argument applies to any decision affecting the general good; it does not require that these economic effects be mediated by illness. One familiar argument for strong anti-smoking programs is the cost to society of lost work days due to smoking-related disability. The same sort of loss occurs when a person who could be very productive in one profession chooses another instead which requires talents he lacks; or when someone decides simply to work less and accept a lower income . . . . The success of the utilitarian argument for coercive life-style reform, then, depends on being able to furnish a moral principle which [sic] distinguishes these basic freedoms from others which are not basic. Such a criterion would serve to show, perhaps, that choice of domicile, family size, or career are protected by right, while the liberties to smoke or eat large quantities of red meat may be withdrawn at society’s convenience. Unfortunately, moral philosophy has not provided such criterion to date”).

\textsuperscript{174}See \textit{Feinberg, Paternalism, supra} note 145, at 105 (explaining “[t]he principle of legal paternalism justifies state coercion to protect individuals from self-inflicted harm, or in its extreme version, to guide them, whether they like it or not, toward their own good”). For comments on public health paternalism see \textit{infra} notes 187-88.

\textsuperscript{175}Goodin, \textit{supra} note 121, at 579.

\textsuperscript{176}JOHN STUART MILL, \textit{ON LIBERTY} 71 (David Spitz, ed., 1775).

\textsuperscript{177}Id.
best interests. The courts have found that the right to self-determination is firmly based in the Constitution. These autonomous decisions, regardless if deemed senseless, are to be respected. These established rights of self-determination for health decisions do extend to health hazardous lifestyles.

Mill's argument is convincing. However, it is not relevant to the debate about health hazardous behavior. After closer examination of several paternalistic proposals to penalize perilous health behaviors, a discrepancy surfaced between what was touted as a paternalistic intent and what was the actual intent of the restriction. For instance, many restrictions justified under the auspices of harm to the smoker are actually proposed with the plan of decreasing health care costs and minimizing the economic harm to the community. If the aim of the proposal is to have positive effects on society, than the proposal’s design is clearly not intended to protect the individual from harm to herself. Instead, the proposal is meant to protect the community from harm. The intent of
patient liability for disease is not to protect the individual from harm to herself, therefore a paternalistic justification is not warranted.

**Harm Principle**

The last justification, preventing harm to other individuals, is the only liberty limiting proposal that has been relatively agreed upon.\(^{133}\) However, what actually constitutes harm is not readily apparent, and the definition allows considerable room for disagreement. Harm is defined as “the violation of an [other’s] interest” and an interest is something in which one has a stake.\(^{134}\) The intention of this constricted definition was to exclude sweeping claims of harm to society as a whole or vague non-perceptible individual claims.\(^{135}\) However, there are no generalized duties that health violators owe to the public.\(^{136}\) The notion of the harm principle would not be applicable to the claim of harm to the community. In fact, individual differences in society should be valued even if, ostensibly, the differences are unfavorable.\(^{137}\) Possibly a few limited exceptions to the harm principle exist, which are related to public health.\(^{138}\) However, the

largely irrelevant to public health measures... health educators may regard themselves as justified in influencing policy makers to enact laws to control smoking, alcohol, fluoridated water, insurance rates, and other health-related matters not because they are thereby protecting people against themselves, but rather because such practices harm the health of other persons, cost society too much money, potentially can protect the health of many persons, tend to disrupt families, etc\(^{\text{.}}\).\(^{133}\) See MILL, supra note 176, at 10-11 (expressing “the only purpose for which power can be rightfully exercised over any member of a civilised [sic] community, against his will, is to prevent harm to others”).

\(^{134}\) See FEINBERG, RIGHTS, JUSTICE, AND THE BOUNDS OF LIBERTY 71 (1980) [hereinafter FEINBERG, BOUNDS OF LIBERTY].

\(^{135}\) See, MILL, supra note 176, at 76 (clarifying “with regard to the merely contingent, or as it may be called, constructive injury which a person causes to society, by conduct which neither violates any specific duty to the public, nor occasions perceptible hurt to any assignable individual except himself; the inconvenience is one which society can afford to bear, for the sake of the greater good of human freedom”).

\(^{136}\) See Dworkin, supra note 14, at 27 (discussing role-responsibility he notes there must be a “place in social life, which carries with it certain duties and/or obligations.”). Cf. MILL, supra note 176, at 76 (discussing the differences of duty owed to society of a general person and that of a soldier or a policeman).

\(^{137}\) See MILL, supra note 176, at 91 (expressing that “[individuality] will do so [stand its ground] with increasing difficulty, unless the intelligent part of the public can be made to feel its [individuality’s] value — to see that it [individuality] is good there should be differences, even though not for the better, even though, as it may appear to them, some should be for the worse”).

\(^{138}\) See Winick, supra note 179, at 1733 (discussing that “the state’s police power interest in protecting the public health from the spread of a highly contagious disease justified interference in what otherwise would be an area preserved by the Constitution for individual self-determination”). See also Beauchamp, Community, supra note 146, at 33 (discussing public health
harm the health perpetrator creates is mainly economic and the focus of public health paternalism is often to prevent the spread of contagious disease.\textsuperscript{189}

**IMPACT**

As the health care crisis persists, so will the suggestions to shift costs to the individual who partakes in health hazardous lifestyles.\textsuperscript{153} The proposals to punish the health violators for actions deemed voluntary are refutable. While the action may be designated as voluntary or avoidable, it has been shown that social structure and other factors\textsuperscript{191} causally determine health behavior.\textsuperscript{192} Most, not all, individuals never overcome these insurmountable factors. Therefore, much of what the ideology of disease responsibility accomplishes is blaming the victim.\textsuperscript{193} Health perpetrators are touted as "free" to do otherwise; however, they are not given access to resources or education to prevent paternalism of fluoridation of water and wearing of motorcycle helmets. See also Persaud, supra note 157, at 281 (discussing that health care is not denied if an individual does not wear a seatbelt).\textsuperscript{189} Winick, supra note 179, at 1733.

\textsuperscript{153}See Blank, supra note 43, at 1583 (explaining that "in an era of increasingly scarce resources where medical goods and services are rationed, the debate will intensify over the extent to which individual behavior ought to influence rationing decisions").

\textsuperscript{191}See Goodin, supra note 121, at 584 (discussing the impact of addiction and advertising on smoking).

\textsuperscript{192}See Dan E. Beauchamp, Ph.D., Alcoholism As Blaming the Alcoholic, 11 INT’L J. OF THE ADDICTIONS 41, 42 (1976) [hereinafter Beauchamp, Alcoholism] (discussing that "[v]ictim-blaming results from defining social problems in terms of the behavioral failures of the victims of that problem. For example, Moynihan (1965) defined Black poverty as a behavioral inability. Blacks were said to be unable to strive for long-term goals such as education and stable employment. The weakness of the Black family—the absent father, the dominance of the mother—was seen as the root cause of this inability. As Ryan points out, the implication is that if it weren’t for this incapacity, the Black could find his place in society. But—as he says—this conclusion will be hard to accept by those with any insight into the pervasive mechanisms of racism and social inequality. It is likely that collective measures against these inequalities—measures that could affect all members of society—will be needed").

\textsuperscript{193}Crawford, Sin, supra note 22, at 10. See also Beauchamp, Alcoholism, supra note 192, at 43 (explaining that "[t]he heart of victim-blaming is the attempt to explain social problems in terms of the behavior of those who experience the problem. This explanation is always in terms of how this behavior is different from the behavior of the nonproblem group. A principal way in which these differences between the nonproblem majority and the problem minority are stated is in terms of ability or capacity. The majority has some capacity which prevents them from becoming mentally ill, committing crime, becoming poor, etc. The minority, on the other hand, lacks these properties. Hence the task for explanation of a social problem becomes that of explaining the origins of this lack of capacity for the minority").
the hazardous behaviors.\textsuperscript{194} The expectation of individuals to cease perilous health lifestyles should be reciprocated by availability of resources to achieve that goal.\textsuperscript{195} Without resources, the proclamation of "individual responsibility for health" becomes meaningless and unattainable.

This victim-blaming ideology will have a disproportionate effect on the marginalized groups -- specifically, those who are uneducated and fall in the lower socio-economic status. Numerous studies have targeted income and education as inversely related to mortality outcomes\textsuperscript{196} and directly related to health risk behaviors.\textsuperscript{197} In fact, individuals in the lower socio-economic status have "a significantly higher prevalence of health risk behaviors."\textsuperscript{198} These individuals who will be blamed for their health hazardous behaviors are exactly the same individuals who already have a problem receiving adequate access to health care. Thus, blaming those individuals will further isolate them from the health care system. These health perpetrators, even if educated on how to improve their health behaviors, will still have to contend with the other wide range of factors that cause this group to partake in hazardous behaviors.\textsuperscript{199} These factors include: differences in exposure to occupational and environmental hazards, unequal access to health care, and the social force in the socio-economic stratification.\textsuperscript{200}

\textbf{[T]he problem of lifestyle and mortality is not just one of inadequate education or income, and the problem of socio-economic differentials in mortality is not just a problem of lifestyle choices. We must look to a broader range of

\textsuperscript{194}See Redford B. Williams, M.D., \textit{Lower Socioeconomic Status and Increased Mortality: Early Childhood Roots and the Potential for Successful Interventions}, 279 JAMA \textbf{1745}, 1745 (1998) (discussing that "[i]nstead of simply targeting risky health behaviors, any effective intervention to ameliorate the impact of lower SES [socioeconomic status] on health and disease will need also to reduce hostility, depression, and social isolation—and perhaps correct autonomic imbalance as well").

\textsuperscript{195}Knowles, \textit{supra} note 14, at 78.

\textsuperscript{196}Lantz, \textit{supra} note 133, at 1703.

\textsuperscript{197}Id. at 1706.

\textsuperscript{198}Id.

\textsuperscript{199}Id. at 1707-08.

\textsuperscript{200}Id. at 1707.
explanatory risk factors, including structural elements of inequality in our society.\textsuperscript{201}

Without consideration of the construction of society, including occupational and environmental hazards, the broader picture of all the factors that contribute to disease is missed. By isolating the individual, other disease-causing factors remain blameless and overlooked. Incentives to change these occupational and environmental factors are reduced when the individual shoulders the blame for disease. By solely focusing on the individual the complexity of disease causation is minimized. Overall, shifting the focus away from these other causal factors does not work to the advantage of society. In fact, this could hurt individuals who will develop disease due to either occupational or environmental factors. Due to the diverted attention, the other causal factors do not receive their due blame and as a result these harmful contributions are never acknowledged or rectified. Instead of suggesting that distribution of burdens related to health hazardous behaviors is "just," what might be more "just" is breaking down the protection of the most powerful organizations in society and controlling the hazards they create.\textsuperscript{202}

Victim-blaming currently serves the purpose of reducing and denying costly health care during a medical cost crisis. As indicated in the first section, which elucidated the reason for the surfacing trend of individual culpability, economics plays a primary role in suggesting an individual's accountability for harmful health behaviors. Victim-blaming allows for a continued disregard of the effects of social implications on health behaviors. Instead of altering the social structure to accommodate the individual's needs and to promote better health, the individual is identified as the problem thus justifying the shift of costs and responsibility to the health violator.\textsuperscript{203}

\textsuperscript{201}Lantz, supra note 133, at 1708.
\textsuperscript{202}See Dan E. Beauchamp, Public Health as Social Justice, in ETHICAL ISSUES IN MODERN MEDICINE 516 (John Arras and Robert Hunt eds., 2nd ed., 1983) (suggesting the issue of justice should focus on restructuring of society having the most powerful and numerous accept new burdens on behalf of the least powerful or the least numerous).
\textsuperscript{203}Crawford, Sin, supra note 22, at 15.
CONCLUSION

In summary, it is not warranted to accept the proposals of patient responsibility associated with lifestyle choices. Unless these suggestions can justify the claims of both individual culpability and liability, this victim-blaming ideology should be abandoned. Instead of denying health care to these health violators, more education and accessibility to resources should be provided before placing responsibility for an individual’s disease. The transaction costs for allowing punishment of health deleterious behaviors far outweighs the benefits. The proponents of the proposals need to consider the aftermath that would be created by such health policies:

[A] health care system that has become too selective in terms of whom it treats carries with it the seed of its own destruction. Our system has been built . . . on a tradition of pluralism . . . and voluntary giving; a tradition of faith, hope, and charity. Should the public lose faith in that arrangement . . . the very basis of the health care system is in jeopardy.204

In the tradition of pluralism, society must realize that individuals weigh the costs of health hazardous behaviors against the possibility of disease differently—not every person values a decreased risk of disease over smoking, drinking, overeating, or sedentary lifestyle.

204Friedman, supra note 5, at 2495.