Millbank Memorial Fund Quarterly/*Health and Society, Vol. 56, No. 3, 1978*

Persuasion and Coercion for Health

Ethical Issues in Government Efforts to Change Life-Styles

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WHAT SHOULD be the government's role in promoting the kinds of personal behavior that lead to long life and good health? Smoking, overeating, and lack of exercise increase one's chances of suffering illness later in life, as do many other habits. The role played by life-style is so important that, as stated by Fuchs (1974): "The greatest current potential for improving the health of the American people is to be found in what they do and don't do for themselves." But the public has shown little spontaneous interest in reforming. If the government uses the means at its disposal to remedy the situation, it may be faced with problems of an ethical nature. Education, exhortation, and other relatively mild measures may not prove effective in inducing self-destructive people to change their behavior. Attention might turn instead to other means, which, though possibly more effective, might also be intrusive or otherwise distasteful. In this essay, I seek to identify the moral principles underlying a reasoned judgment on whether stronger methods might justifiably be used, and, if so, what limits ought to be observed.

0026-3745-78-5603-0303-36/$01.00/0

Background To Government Involvement in Life-Style Reform

This inquiry occurs at a time when the government is widening its scope of involvement in life-style reform. Major prospective health policy documents of both the United States (Department of Health Education, and Welfare, 1975) and Canadian governments (documented by Lalonde, 1974) have announced a change of orientation in this direction. Behind this shift is a host of factors, one of which is the pattern of disease in which an increasing share of ill health is attributed to chronic illnesses and accidental injuries that are aggravated by living habits. This development has caused increased interest in preventive behavioral change, and has been abetted by the current wave of "therapeutic nihilism," an attitude that questions medical intervention and is more friendly to health efforts that begin and end at home.

That life-style reform should be undertaken by the *government,* rather than by private individuals or associations, is part of the general emergence of the government as health-care provider. Encouragement of healthful living may also have a budgetary motive. Government officials may find that life-style reform is one of the most cost-effective ways of delivering health, especially if more effective change-inducing techniques are developed.[1] Indeed, the present cost-containment crisis may propel life-style reform to a central place in health planning before the necessary scientific and policy thinking has taken place.

Further pressure on the government to take strong steps to change unhealthy life-styles might come from those who live prudently. All taxpayers have a stake in keeping federal health costs down, but moderate persons may particularly view others' self-destructive life-styles as a kind of financial aggression against them. They may be expected to intensify their protest in the event of a national health insurance plan or national health service.

Involvement of the government in legislating healthful patterns of living is not wholly new; there have been public health and labor

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[1]Though there is much dispute over the effectiveness of many health-promotion measures, efficient techniques may be developed in step with the progress of behavioral medicine generally. See Ubell (1972), Pomerleau, Bass, and Crown, (1975), and Haggerty (1977).

laws for a long time. Still, with the increased motivation for government action in life-style reform, it is time to reflect on the kinds of interventions the public wants and should have to accept. Various sorts of behavior change measures need to be examined to see if they might be used to induce healthier living. But that is not enough; goals must also be identified and subjected to ethical examination.[2]

The discussion below will examine a small number of possible goals of government life-style reform, and follow with a survey of the principal kinds of steps now contemplated. The approach will be to devote attention to those behavior change measures that are likely to be unpleasant and unwelcome. Since most techniques now used or contemplated for future use do not have such properties, there is little need to justify or focus on them. The reader should also note that each possible policy goal will be discussed in isolation from others. Although in actuality most government programs would probably be expected to serve several purposes at once, and some might be justified by the aggregate but not by one end alone, it is best for our purposes to consider one goal at a time so as to determine the contribution of each. Finally, my analysis should be understood as independent of certain political currents with which my views might be associated. There is some danger that attention to health-related personal behavior will distract the government and public from examining other sources of illness, such as unsafe working conditions, environmental health hazards, and even social and commercial

[2]I am not attempting to determine what the actual goals of the government are in intervening in life-style; indeed, it may make little sense to speak of specific goals at all. (See MacCallum (1966).) The rationale for legislation as voiced by the legislature may have the purpose of establishing the legal basis for the legislation rather than that of exhibiting the legislators' goals in passing the measures or of identifying the need to which the measure was a response.

For example, a bill requiring motorcyclists to wear helmets might be accepted by the public on paternalistic grounds, but the personal motivation of the legislators may have been harassment of the cyclists. And the measure might be upheld in court as a legitimate attempt to prevent the public from being saddled with the cost of caring for injured cyclists who could not afford to pay for medical care.

My inquiry into the goals of a proposed health policy has the sole purpose of determining whether the goal of the policy and the means to it are legitimate. Thus, if it is decided that such a helmet law is unwarranted, even on the paternalistic grounds which seem most applicable, it will not concern us that the law could be cleared through the courts by nimble use of the possibility of the cyclists becoming public charges. This is not to denigrate the use of such methods in the practice of legislation and legal challenge; but these pursuits are different from those undertaken here.

determinants of the injurious behavior. Further, undue stress upon the individual's role in the cause of illness could lead to a "blame-the-victim" mentality, which could be used as a pretext for failing to make curative services available. Although these matters are essentially external to the issue of reform of unhealthy living habits, they pose ethical questions of equal or greater moral gravity.

Goals of Health Behavior Reform

I propose to discuss three possible goals of health behavior reform with regard to their appropriateness as goals of government programs and the problems arising in their pursuit. The first goal can be simply stated: health should be valued for its own sake. Americans are likely to be healthier if they can be induced to adopt healthier habits, and this may be reason enough to try to get them to do so. The second goal is the fair distribution of the burdens caused by illness. Those who become ill because of unhealthy life-styles may require the financial support of the more prudent, as well as the sharing of what may be scarce medical facilities. If this is seen as unfair to those who do not make themselves sick, life-style reform measures will also be seen as accomplishing distributive justice. The third goal is the maintenance and improvement of the general welfare, for the nation's health conditions have their effects on the economy, allocation of resources, and even national security.

Health as a Goal in Itself: Beneficence and Paternalism

Much of the present concern for the reform of unhealthy life-styles stems from concern over the health of those who live dangerously. Only a misanthrope would quarrel with this goal. There are several steps that might immediately be justified: the government could make the effects of unhealthy living habits known to those who practice them, and sponsor research to discover more of these facts. The chief concern over such efforts might be that the government would begin its urgings before the facts in question had been firmly established, thus endorsing living habits that might be useless or detrimental to good health.

Considerably more debate, however, would arise over a decision to use stronger methods. For example, a case in point might be a

government "fat tax," which would require citizens to be weighed and taxed if overweight. The surcharges thus derived would be held in trust, to be refunded with interest if and when the taxpayers brought their weight down.[3] This pressure would, under the circumstances, be a bond imposed by the government upon its citizens, and thus can be fairly considered as coercive.

The two signal properties of this policy would be its aim of improving the welfare of obese taxpayers, and its presumed unwelcome imposition on personal freedom. (Certain individual taxpayers, of course, might welcome such an imposition, but this is not the ordinary response to penalties.) The first property might be called "beneficence," and it is generally a virtue. But the second property becomes paternalism;[4] and its status as a virtue is very much in doubt. "Paternalism" is a loaded word, almost automatically a term of reprobation. But many paternalistic policies, especially when more neutrally described, attract support and even admiration. It may be useful to consider what is bad and what is good about paternalistic practices, so that we might decide whether in this case the good outweighs the bad. For detailed discussions of paternalism in the abstract, see Feinberg (1973), Dworkin (1971), Bayles (1974), and Hodson (1977).

What is good about some paternalistic interventions is that people are helped, or saved from harm. Citizens who have to pay a fat tax, for example, may lose weight, become more attractive, and live longer. In the eyes of many, these possible advantages are more than offset by the chief fault of paternalism, its denying persons the chance to make their own choices concerning matters that affect them. Self-direction, in turn, is valued because people usually believe themselves to be the best judges of what is good for them, and because the choosing is considered a good in itself. These beliefs are codified in our ordinary morality in the form of a moral right to noninterference so long as one does not adversely affect the interests of

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[3]This measure was concocted for the present essay, but it shares its important features with others which have been actually proposed.

[4]"Coercive beneficence" is not a fully correct definition of paternalism; but I will not attempt to give adequate definition here (see Gert and Culver, 1976). The term itself is unnecessarily sex-linked; "Parentalism" carries the same meaning without this feature. However, "paternalism" is a standard term in philosophical writing, and a change from it invites confusion.

others. This right is supposed to shield an individual's "self-regarding" actions from intervention by others, even when those acts are not socially approved ones and even when they promise to be unwise.

At the same time, the case for paternalistic intervention on at least some occasions seems compelling. There may be circumstances in which we lose, temporarily or permanently, our capacity for competent self-direction, and thereby inflict harm upon ourselves that serves little purpose. Like Ulysses approaching the Sirens, we may hope that others would then protect us from ourselves. This sort of consideration supports our imposed guardianship of children and of the mentally retarded. Although these persons often resent our paternalistic control, we reason that we are doing what they would want us to do were their autonomy not compromised. Paternalism would be a benefit under the sort of social insurance policy that a reasonable person would opt for if considered in a moment of lucidity and competence (Dworkin, 1971).

Does this rationale for paternalism support governmental coercion of competent adults to assure the adoption of healthy habits of living? It might seem to, at first sight. Although these adults may be generally competent, their decision-making abilities can be compromised in specific areas. Individuals may be ignorant of the consequences of their acts; they may be under the sway of social or commercial manipulation and suggestion; they may be afflicted by severe psychological stress or compulsion; or be under external constraint. If any of these conditions hold, the behavior of adults may fail to express their settled will. Those of us who disavow any intention of interfering with free and voluntary risk-taking may see cause to intervene when a person's behavior is not under his or her control.

Paternalism: Theoretical Problems. There are a number of reasons to question the general argument for paternalism in the coercive eradication of unhealthful personal practices. First, the analogy between the cases of children and the retarded, where paternalism is most clearly indicated, and of risk-taking adults is misleading. If the autonomy of adults is compromised in one or more of the ways just mentioned, it might be possible to restore that autonomy by attending to the sources of the involuntariness; the same cannot ordinarily be done with children or the retarded. Thus, adults who are destroying their health because of ignorance may be educated; adults acting

under constraint may be freed. If restoration of autonomy is a realistic project, then paternalistic interference is unjustified. The two kinds of interventions are aimed at the same target, *i.e.*, harmful behavior not freely and competently chosen. But they accomplish the result differently. Paternalistic intervention blocks the harm; education and similar measures restore the choice. The state or health planners would seem obligated to use this less restrictive alternative if they can. This holds true even though the individuals might still engage in their harmful practices once autonomy is restored. This would not call for paternalistic intervention, since the risk would be voluntarily shouldered.

It remains true, however, that autonomy sometimes cannot be restored. It may be impossible to reach a given population with the information they need; or, once reached, the persons in question may prove ineducable. Psychological compulsions and social pressures may be even harder to eradicate. In these situations, the case for paternalistic interference is relatively strong, yet even here there is reason for caution. Persons who prove incapable of absorbing the facts about smoking, for example, or who abuse drugs because of compulsion or addiction, may retain a kind of second-order autonomy. They can be told that they appear unable to accept scientific truth, or that they are addicted; and they can then decide to reconsider the facts or to seek a cure. In some cases these will be decisions that the individuals are fully competent to carry out; paternalistic intervention would unjustly deny them the right to control their destinies. Coercion would be acceptable only if this second-order decision were itself constrained, compelled, or otherwise compromised—which, in the case of health-related behavior, it may often be.

A second reason for doubting the justifiability of paternalistic interference concerns the subjectivity of the notion of harm. The same experience may be seen as harmful by one person and as beneficial by another; or, even more common, the goodness (or badness) of a given eventuality may be rated very differently by different persons. Although we as individuals are often critical of the importance placed on certain events by others, we nevertheless hesitate to claim special authority in such matters. Most of us subscribe to the pluralistic ethic, for better or for worse, which has as a central tenet the proposition that there are multiple distinct, but equally valid, concepts of good and of the good life. It follows that

we must use personal preferences and tastes to determine whether our health-related practices are detrimental.

Unfortunately, it is often difficult to defer the authority of others in defining harm and benefit. It is common to feel that one's own preferences reflect values that reasonable people adopt; one can hardly regard oneself as unreasonable. To the extent that government planners employ their own concepts of good in attempting to change health practices for the public's benefit, the social insurance rationale for paternalism is clearly inapplicable.

A third reason for criticism of paternalism is the vagueness of the notion of decision-making disability. The conscientious paternalist intervenes only when the self-destructive individual's autonomy is compromised. It is probably impossible, however, to specify a compromising condition. To be sure, there are cases in which the lack of autonomy is evident, such as that of a child swallowing dangerous pills in the belief that they are candy. But the sorts of practices that would be the targets of coercive campaigns to reform health-related behavior are less dramatic and their involuntary quality much less certain. Since the free and voluntary conditions of health-related practice cannot be specified in advance, there is obviously considerable potential for unwarranted interference with fully voluntary choices.

Indeed, the dangers involved in disregarding individuals' personal values and in falsely branding their behavior involuntary are closely linked. In the absence of independent criteria for decision-making disability, the paternalist may try to determine disability by seeing whether the individual is rational, *i.e.*, whether he or she competently pursues what is valuable. An absence of rationality may be reason to suspect the presence of involuntariness and hence grounds for paternalism. The problem, however, is that this test for rationality—whether the chosen means are appropriate for the individual's personal ends—is not fully adequate. Factors that deprive an individual of autonomy—such as compulsion or constraint—not only affect a person's ability to calculate means to ends but also induce ends that are in some sense foreign. Advertisements, for example, may instill desires to consume certain substances whose pleasures would ordinarily be considered trifling. Similarly, ignorance may induce people to value a certain experience because they believe it will lead to their attainment of other ends. Alcoholics, for example, may value intoxication because they think it will enhance their social

acceptance. The paternalist on the lookout for non-autonomous, self-destructive behavior will be interested not only in irrational means but also uncharacteristic, unreasonable values.

The difficulty for the paternalist at this point is plain. The desire to interfere only with involuntary risk-taking leads to designating individuals for intervention whose behavior proceeds from externally-instilled values. Pluralism commits the paternalist to use the persons' own values in determining whether a health-related practice is harmful. What is needed is some way of determining individuals' "true" personal values; but if these cannot be read off from their behavior, how can they be known?

In certain individual cases, a person's characteristic preferences can be determined from wishes expressed before losing autonomy, as was Ulysses' desire to be tied to the mast. But this sort of data is hardly likely to be available to government health planners. The problem would be at least partially solved if we could identify a set of goods that is basic and appealing, and that nearly all rational persons value. Such universal valuation would justify a presumption of involuntariness should an individual's behavior put these goods in jeopardy. On what grounds would we include an item on this list? Simple popularity would suffice: if almost everyone likes something, such approval probably stems from a common human nature, shared by even those not professing to like that thing. Hence we may suspect, that, if unconstrained, they would like it also. Alternatively, there may be experiences or qualities that, while not particularly appealing in themselves, are preconditions to attaining a wide variety of goods that people idiosyncratically value. Relief from pain is an example of the first sort of good; normal-or-better intelligence is an instance of the latter.

The crucial question for health planners is whether *health* is one of these primary goods. Considered alone, it certainly is: it is valued for its own sake; and it is a means to almost all ends. Indeed, it is a necessary good. No matter how eccentric a person's values and tastes are, no matter what kinds of activities are pleasurable, it is impossible to engage in them unless alive. Most activities a person is likely to enjoy, in fact, require not only life but good health. Unless one believes in an afterlife, the rational person must rate death as an incomparable calamity, for it means the loss of everything.

But the significance of health as a primary good should not be overestimated. The health planner may attempt to argue for coercive

reform of health-destructive behavior with a line of reasoning that recalls Pascal's wager.[5] Since death, which precludes all good experience, must receive an enormously negative valuation, contemplated action that involves risk of death will also receive a substantial negative value after the good and bad consequences have been considered. And this will hold true even if the risk is small, since even low probability multiplied by a very large quantity yields a large quantity. Hence anyone who risks death by living dangerously must, on this view, be acting irrationally. This would be grounds for suspecting that the life-threatening practices were less than wholly voluntary and thus created a need for protection. Further, this case would not require the paternalistic intervenor to turn away from pluralistic ideals, for the unhealthy habits would be faulted not on the basis of deviance from paternalistic values, but on the apparent lapse in the agent's ability to understand the logic of the acts.

This argument, or something like it, may lie behind the willingness of some to endorse paternalistic regulation of the life-styles of apparently competent adults. It is, however, invalid. Its premises may sometimes be true, and so too may its conclusion, but the one does not follow from the other. Any number of considerations can suffice to show this. For example, time factors are ignored. An act performed at age 25 that risks death at age 50 does not threaten every valued activity. It simply threatens the continuation of those activities past the age of 50. The argument also overlooks an interplay between the possible courses of action: if every action that carries some risk of death or crippling illness is avoided, the enjoyment of life decreases. This makes continued life less likely to be worth the price of giving up favorite unhealthy habits.[6] Indeed,

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[5]The agnostic should adopt the habits which would foster his own belief in God. If he does and God exists, he will receive the infinite rewards of paradise; if he does and God does not exist, he was only wasting the efforts of conversion and prayer. If he does not try to believe in God, and religion is true, he suffers the infinitely bad fate of hell; whereas if God does not exist he has merely saved some inconvenience. Conversion is the rational choice even if the agnostic estimates the chances of God's existing as very remote, since even a very small probability yields a large index when multiplied against an infinite quantity.

[6]Readers of the previous footnote might note that a similar difficulty attends Pascal's wager. If the agnostic took steps to foster belief in every diety for which the chance of existing was greater than zero, the inconvenience suffered would be considerable, after all. Yet such would be required by the logic of the wager.

although it may be true that death would deny one of all chances for valued experiences, the experiences that make up some people's lives have little value. The less value a person places on continued life, the more rational it is to engage in activities that may brighten it up, even if they involve the risk of ending it. Craig Claiborne (1976), food editor of *The New York Times*, gives ebullient testimony to this possibility in the conclusion of his "In Defense of Eating Rich Food":

> I love hamburgers and chili con carne and hot dogs. And foie gras and sauternes and those small birds known as ortolans. I love banquettes of quail eggs with hollandaise sauce and clambakes with lobsters dipped into so much butter it dribbles down the chin. I like cheesecake and crepes filled with cream sauces and strawberries with crème fraîche . . .
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> And if I am abbreviating my stay on this earth for an hour or so, I say only that I have no desire to be a Methuselah, a hundred or more years old and still alive, grace be to something that plugs into an electric outlet.

The assumption that one who is endangering one's health must be acting irrationally and involuntarily is not infrequently made by those who advocate forceful intervention in suicide attempts; and perhaps some regard unhealthy life-styles as a sort of slow suicide. The more reasonable view, even in cases of imminent suicide, seems rather to be that *some* unhealthy or self-destructive acts are less-than-fully voluntary but that others are not. Claiborne's diet certainly seems to be voluntary, and suggests that the case for paternalistic intervention in life-style cannot be made on grounds of logic alone. It remains true, however, that much of the behavior that leads to chronic illness and accidental injury is not fully under the control of the persons so acting. My thesis is merely that, first, this involuntariness must be shown (along with much else) if paternalistic intervention is to be justified; and, second, this can only be determined by case-by-case empirical study. Those who advocate coercive measures to reform life-styles, whose motives are purely beneficent, and who wish to avoid paternalism except where justified, might find such study worth undertaking.

Any such study is likely to reveal that different practitioners of a given self-destructive habit act from different causes. Perhaps one obese person overeats because of an oral fixation over which he has no control, or in a Pavlovian response to enticing television food advertisements. The diminished voluntariness of these actions lends

support to paternalistic intervention. Claiborne has clearly thought matters through and decided in favor of a shorter though gastronomically happier life; to pressure him into changing so that he may live longer would be a clear imposition of values and would lack the justification provided in the other person's case.

The trouble for a government policy of life-style reform is that a given intervention is more likely to be tailored to practices and habits than to people. Although we may someday have a fat tax to combat obesity, it would be surprising indeed to find one that imposed charges only on those whose obesity was due to involuntary factors. It would be difficult to reach agreement on what constituted diminished voluntariness; harder still to measure it; and perhaps administratively impractical to make the necessary exceptions and adjustments. We may feel, after examining the merits of the cases, that intervention is justified in the compulsive eater's life-style but not in the case of Claiborne. If the intervention takes the form of a tax on obesity *per se,* we face a choice: Do we owe it to those like Claiborne *not* to enforce alien values more than we owe it to compulsive overeaters to protect them from self-destruction? The general right of epicures to answer to their own values, a presumptive right conferred by the pluralistic ethic spoken of earlier, might count for more than the need of compulsive overeaters to have health imposed on them, since the first violates a right and the second merely confers a benefit. But the situation is more complex than this. The compulsive overeater's life is at stake, and this may be of greater concern (everything else being equal) than the epicure's pleasures. Then, too, the epicure is receiving a compensating benefit in the form of longer life, even if this is not a welcome exchange. And there may be many more compulsive overeaters than there are people like Claiborne. On the other hand, the positive causal link between tax and health for either is indirect and tenuous, while the negative relation between tax and gastronomic pleasure is relatively more substantial. (For a fuller discussion of this type of trade-off, see Bayles [1974].) Perhaps the firmest conclusion one may draw from all this is that a thoroughly reasoned moral rationale for a given kind of intervention can be very difficult to carry out.

Paternalism: Problems in Practice. Even if we accept the social insurance rationale for paternalism in the abstract, then, there are

theoretical reasons to question its applicability to the problem of living habits that are injurious to health. It is still possible that in some instances these doubts can be laid to rest. We may have some noncircular way of determining when self-destructive behavior is involuntary; we may have knowledge of what preferences people would have were their behavior not constrained; and there may be no way to restore their autonomy. While at least a *prima facie* case for paternalistic intervention would exist under such circumstances, I think it is important to note several practical problems that could arise in any attempt to design and carry out a policy of coercive lifestyle reform.

First, there is the distinct possibility that the government that takes over decision-making power from partially-incompetent individuals may prove even less adept at securing their interests than they would have been if left alone. Paucity of scientific data may lead to misidentification of risk factors. The primitive state of the art in health promotion and mass-scale behavior modification may render interventions ineffective or even counterproductive. And the usual run of political and administrative tempests that affect all public policy may result in the misapplication of such knowledge as is available in these fields. These factors call for recognizing a limitation on the social insurance rationale for paternalism. If rational persons doubt that the authorities who would be guiding their affairs during periods of their incompetence would themselves be particularly competent, they are unlikely to license interventions except when there is a high probability of favorable cost-benefit trade-off. This yields the strongest support for those interventions that prevent very serious injuries, and in which the danger posed is imminent (Feinberg, 1973).

These reflections count against a rationale for government involvement in vigorous health promotion efforts, as recently voiced by the Secretary of Health, Education, and Welfare (1975) and found elsewhere (McKeown and Lowe, 1974). Their statements that smoking and similar habits are "slow suicide" and should be treated as such make a false analogy, precisely because suicide often involves certain imminent dangers of the most serious sort in situations in which there cannot be time to determine whether the act is voluntary. This is just the sort of case that the social insurance policy here described would cover; but this would not extend to the self-destruction that takes 30 years to accomplish.

Second, there is some possibility that what would be advertised as concern for the individual's welfare (as that person defines it) would turn out to be simple legal moralism, *i.e.*, an attempt to impose the society's or authorities' moral prescriptions upon those not following them. In Knowles's call for life-style reform (1976) the language is suggestive:

> The next major advances in the health of the American people will result from the assumption of individual responsibility for one's own health. This will require a change in lifestyle for the majority of Americans. The cost of sloth, gluttony, alcoholic overuse, reckless driving, sexual intemperance, and smoking is now a national, not an individual responsibility.[7]

All save the last of these practices are explicit *vices*; indeed, the first two—sloth and gluttony—use their traditional names. The intrusion of non-medical values is evidenced by the fact that of all the living habits that affect health adversely, only those that are sins (with smoking excepted) are mentioned as targets for change. Skiing and football produce injuries as surely as sloth produces heart disease; and the decision to postpone childbearing until the thirties increases susceptibility to certain cancers in women (Medawar, 1977). If it is the unhealthiness of "sinful" living habits that motivates the paternalist toward reform, then ought not other acts also be targeted on occasions when persons exhibit lack of self-direction? The fact that other practices are not ordinarily pointed out in this regard provides no *argument* against paternalistic life-style reform. But those who favor pressuring the slothful to engage in physical exercise might ask themselves if they also favor pressure on habits which, though unhealthy, are not otherwise despised. If enthusiasm for paternalistic intervention slackens in these latter cases, it may be a signal for reexamination of the motives.

A third problem is that the involuntariness of some self-destructive behavior may make paternalistic reform efforts ineffective. To the extent that the unhealthy behavior is not under the control of the individual, we cannot expect the kind of financial threat involved in a

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[7]Elsewhere, however, Dr. Knowles emphasizes that "he who hates sin, hates humanity" (Knowles, 1977). Knowles's argument in the latter essay is primarily nonpaternalistic.

"fat tax" to exert much influence. Paradoxically, the very conditions under which paternalistic intervention seems most justified are those in which many of the methods available are least likely to succeed. The result of intervention under these circumstances may be a failure to change the life-threatening behavior, and a needless (and inexcusable) addition to the individual's woes through the unpleasantness of the intervention itself. A more appropriate target for government intervention might be the commercial and/or social forces that cause or support the life-threatening behavior.

Although the discussion above has focused on the problems attendant to a paternalistic argument for coercive health promotion programs, I have implicitly outlined a positive case for such interventions as well. A campaign to reform unhealthy habits of living will be justified, in my view, so long as it does not run afoul of the problems I have mentioned. It may indeed be possible to design such a program. The relative weight of the case against paternalistic intervention can be lessened, in any case, by making adjustments for the proportion of intervention, benefit, and intrusion. Health-promotion programs that are only very mildly coercive, such as moderate increases in cigarette taxes, require very little justification; noncoercive measures such as health education require none at all. And the case for more intrusive measures would be stronger if greater and more certain benefits could be promised. Moreover, even if the paternalistic rationale for coercive reform of health-related behavior fails completely, there may be other rationales to justify the intrusion. It is to these other sorts of arguments that I now turn.

Fair Distribution of Burdens

The problem of health-related behavior is sometimes seen as a straight-forward question of collective social preference:

> The individual must realize that a perpetuation of the present system of high cost, after-the-fact medicine will only result in higher costs and greater frustration . . . This is his primary critical choice: to change his personal bad habits or stop complaining. He can either remain the problem or become the solution to it; Beneficent Government cannot—indeed, should not—do it for him or to him. (Knowles, 1977)

A good deal of the controversy is due, however, not to any one person's distaste for having to choose between bad habits and high

costs, but rather some people's distaste for having to accept both high costs and someone *else's* bad habits. In the view of these persons, those who indulge in self-destructive practices and present their medical bills to the public are free riders in an economy kept going by the willingness of others to stay fit and sober. Those who hold themselves back from reckless living may care little about beneficence. When they call for curbs on the expensive health practices of others, they want the government to act as their agent primarily out of concern for their interests.

The demand for protection from the costs of calamities other people bring upon themselves involves an appeal to fairness and justice. Both the prudent person and the person with unhealthy habits, it is thought, are capable of safe and healthy living; why should the prudent have to pay for neighbors who decide to take risks? Neighbors are certainly not permitted to set fire to their houses if there is danger of its spreading. With the increasing economic and social connectedness of society, the use of coercion to discourage the unhealthy practices of others may receive the same justification. As the boundary between private and public becomes less distinct, and decisions of the most personal sort come to have marked adverse effects upon others, the state's protective function may be thought to give it jurisdiction over any health-related aspect of living.

This sort of argument presupposes a certain theory of justice; and one who wishes to take issue with the rationale for coercive intervention in health-related behavior might join the debate at the level of theory. Since this debate would be carried out at a quite general level, with only incidental reference to health practices, I will accept the argument's premise (if only for argument's sake) and comment only upon its applicability to the problem of self-destructive behavior. A number of considerations lead to the conclusion that the fairness argument as a justification of coercive intervention, despite initial appearances, is anything but straightforward. Underlying this argument is an empirical premise that may well prove untrue of at least some unhealthy habits: that those who take chances with their health *do* place a significant financial burden upon society. It is not enough to point to the costs of medical care for lung cancer and other diseases brought on by individual behavior. As Hellegers (1978) points out, one must also determine what the individual would have died of had he not engaged in the harmful practice, and subtract

the cost of the care which that condition requires. There is no obvious reason to suppose that the diseases brought on by self-destructive behavior are costlier to treat than those that arise from "natural causes."

Skepticism over the burden placed on society by smokers and other risk-takers is doubly reinforced by consideration of the nonmedical costs and benefits that may be involved. It may turn out, for all we know prior to investigation, that smoking tends to cause few problems during a person's productive years and then to kill the individual before the need to provide years of social security and pension payments. From this perspective, the truly burdensome individual may be the unreasonably fit senior citizen who lives on for 30 years after retirement, contributing to the bankruptcy of the social security system, and using up savings that would have reverted to the public purse via inheritance taxes had an immoderate life-style brought an early death. Taken at face value, the fairness argument would require taxes and other disincentives on *non*-smoking and other healthful personal practices which in the end would sap the resources of the healthy person's fellow citizens. Only detailed empirical inquiry can show which of these practices would be slated for discouragement were the argument from fairness accepted; but the fact that we would find penalties on healthful behavior wholly unpalatable may weaken our acceptance of the argument itself.

A second doubt concerning the claim that the burdens of unhealthy behavior are unfairly distributed also involves an unstated premise. The risk taker, according to the fairness argument, should have to suffer not only the illness that may result from the behavior but also the loss of freedom attendant to the coercive measures used in the attempt to change the behavior. What, exactly, is the cause cited by those complaining of the financial burdens placed upon society by the self-destructive? It is not simply the burden of caring and paying for care of these persons when they become sick. Many classes of persons impose such costs on the public besides the self-destructive. For example, diabetics, and others with hereditary dispositions to contract diseases, incur unusual and heavy expenses, and these are routinely paid by others. Why are these costs not resisted as well?

One answer is that there *is* resistance to these other costs, which partly explains why we do not yet have a national health insurance system. But even those willing to pay for the costs of caring for

diabetics, or the medical expenses of the poor, may still bridle when faced by the needs of those who have compromised their own health. Is there a rationale for resisting the latter kinds of costs while accepting the former? One possible reason to distinguish the costs of the person with a genetic disease from those of the person with a life-style-induced disease is simply that one can be prevented and the other cannot. Health behavior change measures provide an efficient way of reducing the overall financial burden of health care that society must shoulder, and this might be put forward as the reason why self-destructive presons may have their presumptive rights compromised while others with special medical expenses need not.

But this is not the argument we seek. The medical costs incurred by diseases caused by unhealthy life-styles may be preventable, if our behavior-modifying methods are effective; but this fact shows only that there is a utilitarian opportunity for reducing costs and saving health-care dollars. It does *not* show that this opportunity makes it right to burden those who lead unhealthy lives with governmental intrusion. If costs must be reduced, perhaps they should be reduced some other way (*e.g.*, by lessening the quality of care provided for all); or perhaps costs should not be lowered and those feeling burdened should be made to tolerate the expense. The fact that money could be saved by intruding into the choice of life-styles of the self-destructive does not *itself* show that it would be particularly fair to do so.

If intrusion is to be justified on the grounds that unhealthy life-styles impose unfair financial burdens on others, then, something must be added to the argument. That extra element, it seems, is *fault*. Instead of the *avoidability* of the illnesses and their expenses, we point to the *responsibility* for them, which we may believe falls upon those who contract them. This responsibility, it might be supposed, makes it unfair to force others to pay the bills and makes it fair for others to take steps to prevent the behaviors that might lead to the illness, even at the cost of some of the responsible person's privacy and liberty.

The argument thus depends crucially on the premise that the person who engages in an unhealthy life-style is responsible for the costs of caring for the illness that it produces. "Responsible" has many senses, and this premise needs to be stated unambiguously. Since responsibility was brought into the argument in hopes of contrasting life-style-related diseases from others, it seems to involve the

notions of choice and voluntariness. If the chronic diseases resulting from life-style were not the result of voluntary choices, then there could be no assignment of responsibility in the sense in which the term is being used. This would be the case, for example, if a person contracted lung cancer from breathing the smog in the atmosphere rather than from smoking. But what if it should turn out that even a person's smoking habit were the result of forces beyond the smoker's control? If the habit is involuntary, so is the illness; and the smoker in this instance is no more to be held liable for imposing the costs of treatment than would, say, the diabetic. Since much self-destructive behavior is the result of suggestion, constraint, compulsion, and other factors, the applicability of the fairness argument is limited.

Even if the behavior leading to illness is wholly voluntary, there is not necessarily any justification for intervention *by the state*. The only parties with rights to reform life-styles on these grounds are those who are actually being burdened by the costs involved. A wealthy man who retained his own medical facilities would not justifiably be a target of any of these interventions, and a member of a prepaid health plan would be liable to intervention primarily from others in his payments pool. He would then, of course, have the option of resigning and continuing his self-destructive ways; or he might seek out an insurance scheme designed for those who wish to take chances but who also want to limit their losses. These insured parties would join forces precisely to pool risks and remove reasons for refraining from unhealthy practices; preventive coercion would thus be out of the question. Measures undertaken by the government and applied indiscriminately to all who indulge in a given habit may thus be unfair to some (unless other justification is provided). The administrative inconvenience of restricting these interventions to the appropriate parties might make full justice on this issue too impractical to achieve.

This objection may lose force should there be a national health insurance program in which membership would be mandatory. Indeed, it might be argued that existing federal support of medical education, research, and service answers this objection now. But this only establishes another ground for disputing the responsibility of the self-destructive individual for the costs of his medical care. To state this objection, two classes of acts must be distinguished: the acts constituting the life-style that causes the disease and creates the need for care; and the acts of imposing financial shackles upon an

unwilling public. Unless the acts in the first group are voluntary, the argument for imposing behavior change does not get off the ground. Even if voluntary, those acts in the second class might not be. Destructive acts affect others only because others are in financial relationships with the individual that cause the medical costs to be distributed among them. If the financial arrangement is mandatory, then the individual may not have *chosen* that his acts should have these effects on others. The situation will have been this: an individual is compelled by law to enter into financial relationships with certain others as a part of an insurance scheme; the arrangement causes the individual's acts to have effects on others that the others object to; and so they claim the right to coerce the individual into desisting from those acts. It seems difficult to assign to this individual responsibility for the distribution of financial burdens. He or she may (or may not) be responsible for getting sick, but not for having the sickness affect others adversely.

This objection has certain inherent limitations in its scope. It applies only to individuals who are brought into a mandatory insurance scheme against their wishes. Those who join the scheme gladly may perhaps be assigned responsibility for the effect they have on others once they are in it; and certainly many who will be covered in such a plan will be glad of it. Further, the burden imposed under such a plan does not occur until persons who have made themselves sick request treatment and present the bill to the public. Only if treatment is mandatory and all financing of care taken over by the public can the imposition of burden be said to be wholly involuntary.

In any case, certain adjustments could be made in a national health insurance plan or service that would disarm this objection. Two such changes are obvious: the plan could be made voluntary, rather than mandatory; and/or the public could simply accept the burdens imposed by unhealthy life-styles and refrain from attempts to modify them. The first of these may be impractical for economic reasons (in part because the plan would fill up with those in greatest need, escalating costs), and the second only ignores the problem for which it is supposed to be a solution.

There is, however, a response that would seem to have more chance of success: allowing those with unhealthy habits to pay their own way. Users of cigarettes and alcohol, for example, could be made to pay an excise tax, the proceeds of which would cover the costs of treatment for lung cancer and other resulting illnesses. Un-

fortunately, these costs would also be paid by users who are not abusers: those who drink only socially would be forced to pay for the excesses of alcoholics. Alternatively, only those contracting the illnesses involved could be charged; but it would be difficult to distinguish illnesses resulting from an immoderate life-style from those due to genetic or environmental causes. The best solution might be to identify persons taking risks (by tests for heavy smoking, alcohol abuse, or dangerous inactivity) and charge higher insurance premiums accordingly. This method could be used only if tests for these behaviors were developed that were non-intrusive and administratively manageable.[8] The point would be to have those choosing self-destructive life-styles assume the true costs of their habits. I defer to economists for devising the best means to this end.[9]

This kind of policy has its good and bad points. Chief among the favorable ones is that it allows a maximum retention of liberty in

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

[9]The reader may sense a paradox by this point. Taxes on unhealthy habits would avoid inequities involved in life-style reform measures, such as taxes on unhealthy habits. And it is true that some of the steps that might be taken to permit those with unhygienic life-styles to assume the costs incurred might resemble those that could be used to induce them to give the habits up. Despite this, and despite the fact that the two kinds of programs might even have the same effects, I believe that they can and ought to be distinguished. The imposition of a fat tax has a behavior change as its goal. It is this goal that made it a topic for discussion in this paper. It would not be imposed to cover the costs of diseases stemming from unhealthy life-styles—indeed, as the reader will recall, the funds obtained through the tax were to be kept in trust and returned later if and when the behavior changed. In contrast, the taxes being mentioned as part of a "pay-as-you-go" plan would not be imposed as a means to changing behavior. Such a proposal would constitute one way of financing health costs, a topic I am not addressing in the present paper. These taxes would, of course, tend to discourage the behavior in question; but this (welcome) effect would not be their purpose nor provide their rationale (more precisely, *need* not be their purpose). Any program, of course, can serve multiple needs simultaneously. The "pay-as-you-go" tax would succeed as a program even if no behavior change occurred, and the behavior-modifying tax would succeed if behavior did change even if no funds were raised. In any case, surcharges and taxes would be but a few methods among many that might be used to induce behavior change; while they could constitute the whole of a policy aimed to impose costs upon those incurring them.

a situation in which liberty carries a price. Under such a policy, those who wished to continue their self-destructive ways without pressure could continue to do so, provided that they absorbed the true costs of their practices themselves. Should they not wish to shoulder these costs, they could submit to the efforts of the government to induce changes in their behavior. If the rationale for coercive reform is the burden the unhealthy life-styles impose on others, this option seems to meet its goals; and it does so in a way that does not require loss of liberty and immunity from intrusions. Indeed, committed immoderates might have reason to welcome the imposition of these costs. Although their expenses would be greater, they would thereby remove at one stroke the most effective device held by others to justify meddling with their "chosen" life-styles (Detmer, 1976).

The negative side of this proposal stems from the fact that under its terms the only way to retain one's liberty is to pay for it. This, of course, offers very different opportunities to rich and poor. This inequality can be assessed in very different ways. From one perspective, the advantage money brings to rich people under this scheme is the freedom to ruin their own health. Although the freedom may be valued intrinsically (*i.e.*, for itself, not as a means to some other end), the resulting illness cannot; perhaps the poor, who are denied freedom but given a better chance for health, are coming off best in the transaction. From another perspective, however, it seems that such a plan simply adds to the degradation already attending to being poor. Only the poor would be forced to submit to loss of privacy, loss of freedom from pressure, and regulation aimed at behavior change. Such liberties are what make up full citizenship, and one might hold that they ought not to be made contingent on one's ability to purchase them.[10]

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[10]It might be possible to devise charges that would be assessed proportionately to income, so that the "bite" experienced by rich and poor would be about the same. This has not been the pattern in the past: all pay the same tax on a pack of cigarettes. In any case, this adjustment is in no way mandated by the fairness argument. The purpose of the charges would be to permit self-destructive individuals to "pay their own way" and hence remain free to indulge in favored habits. Reducing the amounts charged to low-income persons fails to realize that end; the costs of medical treatment for the poor are not any lower than for the rich. Indeed, being poor may increase the likelihood that the costs of treatment would have to be borne by the public. This suggests a scheme in which charges are assessed *inversely* proportional to income.

The premise that illnesses caused by unhealthy habits impose financial burdens on society, then, does not automatically give cause for adopting strong measures to change the self-destructive behavior. Still, it *may* do so, if the underlying theory of justice is correct and if its application can skirt the problems mentioned here. Besides, justification for such programs may be derived from other considerations.

Indeed, there is one respect in which the combined force of the paternalistic rationale and the fairness argument is greater than the sum of its parts. The central difficulty for the fairness argument, mentioned above, is that much of the self-destructive behavior that burdens the public is not really the fault of the individual; various forces, internal and external, may conspire to produce such behavior independently of the person's will. Conversely, a problem for the paternalist is that much of the harm from which the individual would be "protected" may be the result of free, voluntary choices, and hence beyond the paternalist's purview. The best reason to be skeptical of the first rationale, then, is doubt over the *presence* of voluntariness; the best reason to doubt the second concerns the *absence* of voluntariness. Whatever weighs against the one will count for the other.

The self-destructive individual, then, is caught in a theoretical double-bind: whether the behavior is voluntary or not, there will be at least *prime facie* grounds for coercive intervention. The same holds true for partial voluntariness and involuntariness. This consideration is of considerable importance for those wanting to justify coercive reform of health-related behavior. It reduces the significance of the notion of voluntariness in the pro-intervention arguments, and so serves to lessen concern over the intractable problems of defining the notion adequately, and detecting and measuring its occurrence.

Public Welfare

Aside from protecting the public from unfair burdens imposed by those with poor health habits, there may be social benefits to be realized by inducing immoderates to change their behavior. Health behavior change may be the most efficient way to reduce the costs of health care in this country, and the benefits derived may give reason to create some injustices. Further, life-style reform could yield some

important collective benefits. A healthier work force means a stronger economy, for example, and the availability of healthy soldiers enhances national security.

There may also be benefits more directly related to health. If the supply of doctors and curative facilities should prove relatively inelastic, or if the economy would falter if too much of our resources were diverted to health care, it may be impossible to increase access to needed medical services. The social goal of adequate treatment for all would then not be realizable unless the actual need for medical care were reduced. Vigorous government efforts to change life-styles may be seen as the most promising means to this end.

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

Whether it is permissible to pursue social goods by extracting benefits from disadvantageously situated groups within society is a matter of political ideology and justice. Our society routinely compromises certain of its citizens' interests and privileges for the public good; others are considered inviolate. The question to be decided is whether the practices that we now know to be dangerous to health merit the protection given by the status of right. The significance of this status is that considerations of utility must be very strong before curbing the practice can be justified. Unfortunately, I see no decisive argument that shows that smoking, sloth, and other dangerous enjoyable pastimes are or are not protected by rights. It is worth mentioning, however, that many behaviors of interest to health planners are almost certainly of too trivial significance to aspire to such protection; freedom to drive at 65 miles per hour rather than 55 is an example, as is the privilege of buying medicine in non-childproof containers. Consideration of social utility would seem to justify much that is being currently overlooked in prevention of injury and illness through behavior change.

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

Means of Health Behavior Reform

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

Disagreement over the degree of coerciveness of health behavior change programs is to be expected, not least because of the vagueness of the notion of coercion itself. Some of the most difficult problems addressed in the philosophical literature (Nozick, 1969; Held, 1972; Bayles, 1972; and Pennock, 1972) arise in the present context: What is the difference between persuasion and manipulation? Can offers and incentives be coercive, or is coerciveness a property only of threats? And can one party be said to have coerced another even if the latter manages to accomplish that which the first party tried to prevent?

The answers to these and similar queries will affect the evaluation of various kinds of health promotion measures.

Health Education

Health education seems harmless. Education generally provides information and this generally increases our power, since it enhances the likelihood that our decisions will accomplish our ends. For the most part, there is no inherent ethical problem with such programs,

and they do not stand in need of moral justification. Still, there are certain problems with some health education programs, and these should be mentioned.

Health education *could* be intrusive. Few could object to making information available to those who seek it out. But if "providing information" were taken to mean making sure that the public attained a high level of awareness of the message, the program might require an objectionably high level of exposure. This is primarily an esthetic issue, and is unlikely to cause concern.

Can education be coercive? Information can be used as a tool for one party to get another to do its bidding, just as threats can. But the method is different: Instead of changing the prospective consequences of available actions, which is what a threat does, education alerts one to the previously unrecognized consequences of one's acts. Educators who hope to increase healthful behavior will disseminate only information that points in that direction; they cannot be expected to point out that, in addition to causing deterioration of the liver, alcohol helps certain people feel relaxed in social settings. It is difficult to know whether to regard this selective informing as manipulative. Theoretically, at least, people are free to seek out the other side on their own. Such measures acquire more definite coercive coloration when they are combined with suppression of the other side; "control over the means of persuasion" is another option open to reformers.[11]

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

[11]Though this most clearly recalls the banning of liquor and cigarette advertising from the airwaves, I do not believe that the suppression of information was generally involved. The advertisements did not stress the delivery of information. The quoted phrase is Michael Walzer's (1978).

tors may be led to take a wider view of their role (Rosenstock, 1960). This would include attempts to motivate the public to adopt healthy habits, and this might have to be supplied by covert appeals to other interests ("smokers are unpopular," and so on). Suggestion and manipulation may replace information as the tools used by the health educators to accomplish their purpose. (American Public Health Association, 1975; Haefner and Kirscht, 1970; and Milio, 1976). Indeed, health education may call for actual and deliberate *mis*information: directives may imply or even state that the scientific evidence in favor of a given health practice is unequivocal even when it is not (a problem noted by Lalonde, 1974).

A fine line has been crossed in these endeavors. Manipulation and suggestion go well beyond providing information to enhance rational decision making. These measures bypass rational decision-making faculties and thereby inflict a loss of personal control. Thus, health education, except when restricted to information, requires some justification. The possible deleterious effects are so small that the justification required may be slight; but the requirement is there. Ethical concerns for this kind of practice may become more pressing as the educational techniques used to induce behavior change become more effective.[12]

Incentives, Subsidies, and Taxes

Incentive measures range from pleasantly noncoercive efforts such as offering to pay citizens if they will live prudently, to coercive measures such as threatening to fine them if they do not. Various

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[12]See Ubell (1972). It might be objected that the kind of manipulation I am speaking of is practiced continuously by commercial advertisers, and that no justification is provided by or demanded from them. It certainly is true that these techniques are used, but this does not show that there is not a need for justification when they are used in the course of a government health promotion campaign. The fact that the commercials are tolerated may indicate not that the manipulative techniques are themselves unobjectionable, but rather that private interests enjoy First Amendment freedom from regulation in their attempts to communicate with the public. The rationale for this freedom—if it exists—may not apply to government communications. The government *per se* is not an entity with interests which must be protected by rights in society; and the same holds true (officially, at least) of health education advocates, when agents of the government.

noncoercive measures designed to facilitate healthful life-styles might include: providing jogging paths and subsidizing tennis balls. Threats might include making all forms of transportation other than bicycling difficult, and making inconvenient the purchase of food containing saturated fats.

Generally speaking, justification is required only for coercive measures, not for incentives. However, the distinction is not as clear as it first appears. Suppose, for example, that the government wants to induce the obese to lose weight, and that a mandatory national health insurance plan is about to go into effect. The government's plan threatens the obese with higher premiums unless they lose their excess weight. Before the plan is instituted, however, someone objects that the extra charges planned for eager eaters make the program coercive. No adequate justification is found. Instead of calling off the program, however, some subtle changes are made. The insurance scheme is announced with higher premiums than had been originally planned. No extra charges are imposed on anyone; instead, discounts are offered to all those who avoid overweight. Instead of coercion, the plan now uses positive incentives; and this does not require the kind of justification needed for the former plan. Hence the new program is allowed to go into effect.

The effect of the rate structure in the two plans is, of course, identical: The obese would pay the higher rate, the slender the lower one. It seems that the distinction between coercion and incentive is merely semantic. But this is the wrong conclusion. There is a real difference, upon which much ethical evaluation must rest; the problem is in stating what that difference amounts to. A partial answer is that a given measure cannot be judged coercive or noncoercive without referring to a background standard from which the measure's effects diverge favorably or unfavorably. Ultimately, I believe, the judgment required for the obesity measure would require us to decide what a fair rate would have been for the insurance; any charges above that fair rate would be coercive, and any below, incentive. (For an account of this complex subject, see Nozick, 1969). The rate the government plans to charge as the standard premium might not be the fair rate; and this shows that one cannot judge the coerciveness of a fee structure merely by checking it for surcharges.

Even if we are able to sort the coercive from the incentive measures, however, we may have reason to hesitate before allowing the government unlimited use of incentives. A government in a posi-

tion to make offers may not necessarily coerce those it makes the offers to, but is relatively more likely to get its way; in this sense its power increases. Increased government power over life-styles would seem generally to require some justification. In particular, there is inevitably some danger that, given the present scientific uncertainty over the effects of many habits, practices might be encouraged that would contribute nothing to health or even be dangerous. A further problem with financial incentives is that if they are to affect the behavior of the rich they must be sizable; and this may redistribute wealth in a direction considered unjust on other grounds.

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

Regulative Measures

The coercive measures discussed above concentrate on applying influence on individuals so that their behavior will change. A different way of effecting a reform is to deprive self-destructive individuals of the means needed to engage in their unhealthy habits. Prohibition of the sale of cigarettes would discourage smoking at least as effectively as exhortations not to smoke or insurance surcharges for habitual tobacco use. Yet, these regulative measures are surely as coercive, although they do not involve direct interaction with the individuals affected. They are merely one more way of intervening in an individual's decision to engage in habits that may cause illness. As such, they are clearly in need of the same or stronger justification as those involving threats, despite the argument that these measures are taken only to combat an unhealthy *environment,*

and thus cannot be counted as coercing the persons who have unhealthy ways of living (Terris, 1968). For a discussion of this indirect form of paternalism, see Dworkin (1971). What distinguishes these "environmental" causes of illness from, say, carcinogens in the water supply, is the active connivance of the victims. "Shielding" the "victims" from these external forces must involve making them behave in a way they do not choose. This puts regulative measures in the same category as those applied directly to the self-destructive individuals.

Conclusions

I have been concerned with clarifying what sorts of justification must be given for certain kinds of government involvement in the reform of unhealthy ways of living. It is apparent that more is needed than a simple desire on the part of the government to promote health and/or reduce costs. When the measures taken are intrusive, coercive, manipulative, and/or inflict deprivations—in short, when they are of the sort many might be expected to dislike—the moral justification required may be quite complex. The principles that would be used in making a case for these interventions may have limited scope and require numerous exceptions and qualifications; it is unlikely that they can be expressed as simple slogans such as "individuals must be responsible for their own health" or "society can no longer afford self-destructiveness."

My goal has been to specify the kind of justification that would have to be provided for any coercive life-style reform measure. I have not attempted to reach a judgment of right or wrong. Either of these judgments would be foolhardy, if only in view of the diversity of health-promotion measures that have been and will be contemplated. Yet it might be appropriate to recall a few negative and positive points on life-style reform.

Inherent in the subject matter is a danger that reform efforts, however rationalized and advertised, may become "moralistic," in being an imposition of the particular preferences and values of one (powerful) group upon another. Workers in medicine and related fields may naturally focus on the medical effects of everyday habits

and practices, but others may not. From this perspective, trying to induce the public to change its style of living would represent an enormous expansion of the medical domain, a "medicalization of life." The parochial viewpoint of the health advocate can reach absurd limits. A recent presidential address to a prominent professional health organization, for example, came close to calling for abolition of alcohol simply on the grounds that the rate of cirrhosis of the liver had increased by 6 per 100,000 over the last 40 years. In this instance, health is being imposed upon us as a goal from above; perhaps medicine would serve us best if it acted to remove the dangers from the pursuit of other goals.

When the motivation behind life-style reform is concern for taxpayers rather than for self-destructive individuals, problems of a different kind are posed. Insistence that individuals are "responsible" for their own health may stem from a conflation of two different phenomena: an individual's life-style playing a causal role in producing illness, and that individual being at fault and accountable for his or her life-style and illness. The former may be undeniable, but the latter may be very difficult to prove. Unless difficulties in this sort of view are acknowledged, attention may be diverted from the various external causes of dangerous health-related behavior, resulting in a lessening of willingness to aid the person whose own behavior has resulted in illness.

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

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Acknowledgments: The author acknowledges support of the Joseph P. Kennedy, Jr., Foundation and of the Institute of Medicine, National Academy of Sciences; helpful suggestions from Lester Breslow, Don Detmer, Edmund Pellegrino, Michael Pollard, Bernard Towers, members of the Institute's Social Ethics Committee, and *Health and Society's* referees; and numerous points and ideas from Norman Fost, Gerald MacCallum, John Robertson, Norma Wikler, and, particularly, David Mechanic.

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