

Justice for children in healthcare: an asymmetric theory of responsibility

Article

Published Version

Creative Commons: Attribution-Noncommercial 3.0

Open Access

Newey, C. ORCID: <https://orcid.org/0000-0001-5043-3793>
(2016) Justice for children in healthcare: an asymmetric theory of responsibility. *Dilemata: International Journal of Applied Ethics*, 21. pp. 1-21. ISSN 1989-7022 Available at <https://centaur.reading.ac.uk/79138/>

It is advisable to refer to the publisher's version if you intend to cite from the work. See [Guidance on citing](#).

Published version at: <https://www.dilemata.net/revista/index.php/dilemata/issue/view/22>

Publisher: Dilemata

All outputs in CentAUR are protected by Intellectual Property Rights law, including copyright law. Copyright and IPR is retained by the creators or other copyright holders. Terms and conditions for use of this material are defined in the [End User Agreement](#).

www.reading.ac.uk/centaur

CentAUR

Central Archive at the University of Reading

Justice for Children in Healthcare: An Asymmetric Theory of Responsibility

Charlotte Newey
Cardiff University
NeweyC@Cardiff.ac.uk

Justicia para los niños en el sistema sanitario: una teoría asimétrica de la responsabilidad

ABSTRACT: Healthcare providers face enormous pressure to save healthcare resources where possible. In this paper I explore the response that we should allocate resources fairly. What is a fair allocation of healthcare resources for children? First, I consider the luck egalitarianism approach of limiting resources to adult patients who are responsible for their conditions. A luck egalitarian distribution of healthcare resources to adults faces significant problems in application. I maintain that when we consider these problems with a focus on the just distribution of healthcare resources to children, we gain valuable insights into the fairness of healthcare allocation for adults.

RESUMEN: Los proveedores de asistencia sanitaria se enfrentan a una enorme presión para ahorrar recursos sanitarios siempre que sea posible. En este artículo exploró la cuestión sobre el deber de asignar recursos de manera justa. ¿En qué consiste una asignación equitativa de los recursos sanitarios para los niños? En primer lugar, analizo el enfoque del igualitarismo de la suerte en relación a la limitación de recursos para pacientes adultos responsables de sus condiciones. Una distribución de los recursos limitados para pacientes adultos, desde la perspectiva del igualitarismo de la suerte, se enfrenta a problemas significativos en su aplicación. Mantengo que cuando consideramos estos problemas con un enfoque en la distribución justa de los recursos sanitarios para los niños, obtenemos información valiosa sobre la equidad de la asignación de la asistencia sanitaria para los adultos.

KEYWORDS: Fairness, luck egalitarianism, healthcare, responsibility, children's justice

PALABRAS-CLAVE: equidad, igualitarismo de la suerte, asistencia sanitaria, responsabilidad, justicia de los niños

'The time has come for us to be radical and to seize back from the state responsibility for part of our own healthcare'

Sir Thomas Hughes-Hallett, NHS Trust Chair,
speaking on Radio 4's 'Today' programme.

ISSN 1989-7022

TIEMATA año 8 (2016), nº 21, 1-20

1. Introduction

The aim of this paper is twofold. First, I wish to think about fairness and just allocations of children's healthcare resources. Next, I argue that, through a focus on children's healthcare, we gain a new insight into the requirements of justice in healthcare distribution to adults. The structure of this paper is as follows:

I start by demonstrating the pressures on healthcare resources and note some options already suggested by healthcare providers. After a general discussion of luck egalitarianism and responsibility I consider objections to luck egalitarianism in healthcare for adults, noting that the biggest hurdle is a question of application rather than theory. I also highlight



Rebibido: 13/01/2016
Aceptado: 04/04/2016

particular complications applying luck egalitarianism to the distribution of children's healthcare. I turn to Samantha Brennan's recent work in the justification of children's rights, which provides insights into how we might approach the issue of justice in children's healthcare provision. I offer an asymmetric theory of luck egalitarian healthcare provision for children, arguing that healthcare providers should adopt different responses to healthcare risks and outcomes that might arise from 'good' and 'bad' choices made by or on behalf of a child. The asymmetric theory aims to encourage responsible attitudes in children and their guardians. I consider existing and interventions aimed at improving children's health that are consistent with my approach and identify the possible benefits and implications of my theory for children of varying ages and for healthcare resources in the short and longer term. I identify possible objections to my approach in section 10 before I return to the wider topic of luck egalitarianism in healthcare for adults, arguing that we should reform our approach to luck egalitarianism in healthcare for adults.

2. Existing Healthcare Provision: Financial Pressures

Political appeals to fairness are popular in the UK where, rightly or wrongly, 'fairness' is frequently interpreted as being closely connected to merit and only loosely connected to need.¹ The political popularity of fairness therefore explains increased interest in responsibility-sensitive approaches to distributive justice, known in the philosophical literature as 'luck egalitarianism'. The pressure for luck egalitarianism in healthcare distribution stems from the fact that healthcare is a scarce resource. Providing treatment to one patient entails withholding funds that are needed for other patients. There are other approaches and solutions to the problem of scarcity. One approach is to deny that scarcity is itself a problem.² Governments could redirect revenue away from less pressing forms of expenditure, such as redecorating ministerial offices, subsidising certain 'highbrow' arts, and exploring space to the health service. Alternatively, we might acknowledge that scarce resources pose a real problem for healthcare provision and argue for increased taxes. Arguments for these views would be the topic of a different paper, so I set them to one side. Either or both approaches may also turn out to be correct. Nonetheless, it is important to use resources efficiently. Hence, this paper explores the possibility of a longer-term solution that could sit alongside either of the two approaches just mentioned.

Chris Hobson, chief executive of NHS Providers says, "NHS trusts and foundation trusts are doing everything they possibly can to avoid financial deficits, but they are experiencing a triple whammy: rapidly rising patient demand, an extra £2bn unfunded staff cost they have been required to add, and the deepest and longest funding squeeze in NHS history."³ Sir Thomas Hughes-Hallett, NHS Chair, suggests there are three options facing the NHS right now:

- (1) The NHS could continue to offer the full range of services, free of charge, if there was a significant increase in government funding.
- (2) The NHS could restrict free services to emergency and life-saving services or
- (3) The NHS could rely on an "army of volunteers" to care, primarily, for the elderly.

Hughes-Hallett rejects the first option as unlikely, skips over the second and quotes Lord Beveridge's 1942 view that the state "should not take away from the citizen the entrepreneurship of caring for their own healthcare".⁴ These words provide a small foothold from which actual practices of luck egalitarian healthcare distribution might develop. With people living longer, with the increase in obesity, poor diets, and generally low levels of activity, this problem reaches far beyond the UK, albeit in different forms. A "point and blame" culture is emerging within popular culture, fuelled by sensationalist reporting and shallow thinking.⁵ It is therefore very important to consider the potential attractions and pitfalls of holding adults responsible for their own healthcare.

3. Luck Egalitarianism, Responsibility and Healthcare

Luck egalitarianism starts from egalitarian premises: the fact that people matter equally militates in favour of an equal distribution of resources.⁶ But luck egalitarians identify an inherent unfairness in strictly egalitarian distributions: some people put in more effort, or take better care of their resources so it is unfair to redistribute gains resulting from their prudence or effort in pursuit of strict equality. On the other hand some people are simply lucky to have strong genetic inheritances and supportive early environments, so a strictly laissez-faire policy is also inherently unfair.⁷ To redress this unfairness, luck egalitarians holds people responsible for their 'option' luck choices and departures from equality are justified by permitting

an agent to keep the benefits (or suffer the burdens) resulting from the amount of effort they commit to a project or from their prudential (or careless) choices. However, redistributions correcting unfair advantage and disadvantage caused by an agent's 'brute' luck are justified.⁸ I need to say more about responsibility.

3.1. Scanlon and Cohen on Responsibility

T. M. Scanlon identifies two forms of responsibility that are relevant to the luck egalitarian debate.⁹ Responsibility as attributability is a sense of moral responsibility in which a subject is properly assessable for praise or blame. An agent is responsible in this sense if an action reflects the agent's judgement-sensitive attitudes. If Julia's running into her neighbour's burning house reflects her judgement that she must check whether people need assistance, then she is responsible. Substantive responsibility concerns what we owe to each other as a matter of justice and depends the presence of 'eligible' alternatives. For example, Julia is physically capable of staying outside of the burning house but her upbringing, concern for her neighbour's safety, sense of duty and of community remove that option as an 'eligible' alternative. Where the first kind of responsibility obtains but the second does not, it is appropriate to hold an agent morally responsible in the first sense, yet inappropriate to make an agent bear the costs of their choices. If Julia sustains an injury, it would be inappropriate to require her to pay for treatment.

G.A Cohen noted the problem of moral responsibility and free will early in the luck egalitarian debate (1989:934):

Someone might say that to make choice central to distributive justice lands political philosophy in the morass of the free will problem. The distinction between preferences and resources is not metaphysically deep but it is by contrast, awesomely difficult to identify what represents genuine choice.

In response, Cohen suggests that some choices are more genuine than others are. Genuineness of choice comes in degrees. Luck egalitarianism is appropriate only to the extent that redress reflects a lack of genuine choice. Despite the epistemic problems identified, Cohen tells us that the more relevant information an agent had, the less cause for complain he will have about the outcomes that follow from his choices.

3.2. Responsibility for Healthcare

Suppose we take Cohen's suggestion and apply it to the issue of health. We can see that in order for agents to make more, rather than less, genuine choices, agents need to know more about the amount and quality of information available regarding various health related choices. A good example is smoking which is widely regarded as both a personal and a drain on healthcare resources because of the correlation between smoking and certain health problems. However, in the 1920s and 1930s, tobacco giants Lucky Strike, RJ Reynolds and Philip Morris all used physician endorsements in cigarette advertisements. Even when there was some concern about the connection between smoking and health, doctors were encouraged to continue to endorse the brands that were 'least harmful', since the advice not to smoke was portrayed by the tobacco giants as too extreme. A whole generation of new smokers became addicted to tobacco. For that generation and quite possibly the next, the combination of bad advice, smoking role models and the addictive properties of cigarettes give us two reasons to reject responsibility for smoking. First, the choices made by these smokers were not genuine. Secondly, we have seen that we tend not to attribute moral responsibility to acts performed under the influence of constraints, such as addiction.

From the mid-1980s onwards, there has been a considerable increase in information connecting smoking to negative health outcomes. The smoking bans introduced in the UK between 2006 and 2007 helped to reinforce the negative message about the consequences of smoking and aimed to reduce the peer pressure to smoke. We can reasonably assert that the choices available to potential smokers nowadays are more genuine than those facing our grandparents and great-grandparents. Moreover, we have far greater knowledge of the highly addictive properties of nicotine within cigarettes. As such it is less plausible to claim that someone who chooses to smoke is not morally responsible for ensuing health outcomes on the grounds of addiction. I have one caveat. There is credible evidence that some people have more addictive natures than others. There is a morally relevant distinction between one person who becomes addicted to smoking after a single cigarette and another who can smoke occasional cigarettes without developing an addiction.

Richard Arneson makes the last point: 'The more difficult and painful it is for an individual to make a best choice, the less reasonable it is to expect that she will

make that choice.' The point generalises to the practice of attributing responsibility. Someone might argue that we can simply announce to existing and potential smokers that they will be held responsible for smoking-related health outcomes. Unless an individual is capable of making certain choices, it would be unreasonable to expect them to do so and unjust to hold them responsible if they fail.

4. Luck Egalitarian Healthcare Distribution for Adults

Although the provision of healthcare according to luck egalitarianism goes against the perceived ethos of the UK's National Health Service (NHS), this ethos is under pressure because of the financial crisis that the NHS faces.¹⁰ Other commentators have also noted the pressure to think about healthcare distribution from the luck egalitarian perspective.¹¹

Luck egalitarianism in healthcare requires drawing a distinction between those conditions for which we are responsible and those conditions for which we are not. In 2006–07, 46% of total NHS costs (over £43 billion) were due to diseases related to poor diet, physical inactivity, smoking, alcohol and excess weight (Scarborough et al, 2011).

Luck egalitarianism is sometimes said to offer three advantages over a strictly egalitarian distribution of healthcare provision. The first advantage arises from a particular understanding of fairness: it is unfair to use scarce resources to treat someone who has brought their condition upon themselves rather than someone who is innocently in need of care, or so it is said. The second advantage comes from the suggestion that removing the safety net of free healthcare will encourage better choices. If I cannot get treatment for smoking-related cancer, I should be discouraged to smoke. The third advantage is that, in implementing luck egalitarianism, the state sends a clear message to younger (and future) generations about the behaviours that are good for them or, at the least, policy does not appear to support or condone potentially self-damaging behaviours.¹² Despite these apparent advantages, there are significant challenges to luck egalitarianism.

First, many any health conditions have more than one determinant, some of which may be under the agent's control while others may not. I could be genetically

predisposed to develop cancer and I can still increase the chances of developing cancer through certain lifestyle choices that I make. Diet and activity levels, smoking, drinking and being overweight are viewed as lifestyle choices, at least to some extent. But some instances of cancer occur absent the triggers, so the exact financial burden that is directly related to lifestyle choices will be less than £43 billion. How much less, we do not know. This illustrates a critical drawback for the practical application of luck egalitarian healthcare: unless medical research reveals precise methods for determining the exact causes of medical conditions, the application of luck egalitarianism healthcare can only be very coarse grained. For example, higher risk groups who present with conditions associated with those risky behaviours might be given lower priority than another patient who is deemed an “innocent” sufferer.

Suppose the coarse-grained approach above were implemented. Those patients who are genetically predisposed to developing a medical condition and whose trigger behaviour was not, in this instance, the reason why the disease developed would be treated unjustly by a system intended to increase the justice of healthcare distribution. John Harris raises this concern.¹³ The amount of data that would need to be collectable, collected and available at point of care is too vast to implement in principle. Harris also raises as a further worry the issues of intrusion to privacy and abuse of data. These are important concerns but those sufficiently concerned about the unfairness of withholding resources from someone who is morally deserving of medical care, on the grounds of protecting privacy, will still push the claim that fair allocation of resources warrants a degree of intrusion. They might add that concerns about misuse of data are arguments for better data protection; they are not arguments for an unfair allocation of resources.¹⁴

4.1. Social Determinants of Health

Luck egalitarianism has been repeatedly criticised for failing to recognising the impact of social determinants on health.¹⁵ Health outcomes are adversely affected by poverty, unemployment and poor living conditions.¹⁶ The critics of luck egalitarianism claim that such influences undermine individual responsibility. Scanlon, Cohen and Arneson's discussion of responsibility, eligible alternatives and genuine choices seem relevant here. Luck egalitarianism, properly understood, is concerned with factors that reduce eligible alternatives and inhibit an agent's ability to make

good choices.¹⁷ Furthermore, Andreas Andersen notes that luck egalitarianism is a thoroughgoing distributive theory that is not limited to an isolated question of healthcare resource distribution. It is a mistake to claim that luck egalitarians ignore the social determinants of health, since luck egalitarianism will require compensation for those factors beyond an individual's control that undermine her ability to make good personal choices across all areas of her life, health included. This point informs my suggestions in section 7.

Even if we acknowledge that luck egalitarianism requires equalising people's ability to make certain choices, it is still likely that the application of luck egalitarianism to adult healthcare provision will encounter epistemic problems, potentially leading to the risk of other kinds of injustices. I believe we can go some way towards handling the epistemic problems by thinking about the challenges that luck egalitarianism would face if applied to children's healthcare provision.

5. Luck egalitarianism in children's healthcare provision

Evidence shows overwhelmingly that poor parental choices have a negative impact upon children's mental and physical health (Scaglioni et al, 2008, Buchanan and Ten Brinke, 1997). This raises the first challenge for any kind of luck egalitarian distribution of healthcare resources to children. Where an adult makes poor but genuine choices in respect of their own health there may be some justification for restricting care to that adult. However, restricting healthcare services to a child on the grounds of poor parental choices places the consequences of poor choices on the wrong person.

An (unsympathetic) luck egalitarian response could be that the cost of the child's medical provision should be borne by the adult whose actions and choices have negative impact on children's health. Once again, the epistemic issues return to plague the application of such an account. I have identified the difficulties in establishing the extent to which an adult is responsible for her own health, noting the complex array of factors that influence health outcomes.¹⁸ Now consider the number of people and institutions who might influence children's health outcomes: parents, step families, extended families, neighbourhood, schoolteachers and school friends, prevalence of truancy, religious institutions, gangs, social workers and law

enforcement officers. These people and institutions can affect what a child eats, where she goes, how she spends her time and her opportunity to play outdoors. At different childhood stages she may face pressure to drink, smoke, take drugs and/or be sexually active. The people around her will dictate her conception of physical and mental health norms and her understanding of and ability to take responsibility, as she grows older. These myriad influences add many layers of complexity to the epistemic issue of where responsibility for children's health lies.

However, it is important to note that these are all problems of application, though not for the theory itself which, properly applied, would increase the fairness of distributions of goods generally (Albertsen, 2015, 43-5). My concern about the epistemic issue motivates my suggestion that the theory could be adapted.

One argument for holding children responsible for poor choices might be that as children develop and approach adulthood, they sometimes make excellent choices, based upon good reasons and sound reasoning. This line of argument suggests that citing a child's 'lack of capacity' for both choice-making and responsibility-taking presents an unusual challenge. First, the lack of capacity is temporary. Secondly, although children's capacities are not formally recognised, many children demonstrably make better and more rational choices than a number of adults whose choice making capacities, though very poor indeed, are nonetheless recognised and respected. The objection might run that we cannot generalise that children are all wholly or largely irrational, impulsive, irresponsible beings.

The extent to which this is the case is another empirical matter but fortunately, I suggest that we do not need to resolve these empirical questions in order to apply the theory that I propose. Even if it were true that some children demonstrate a capacity for responsible decision-making, it would not affect the account of justice I propose here for the fair provision of healthcare for children. I develop a theory of asymmetric luck egalitarianism for the provision of healthcare to children that will sidestep concerns about both the parties responsible for children's health outcomes and the extent to which we can hold children responsible for their own health.

Before I present my own account, I turn to recent work from Samantha Brennan on the grounding and status of children's rights. Brennan brings a number of insights into the changing needs of children when we consider them not only as children but

also as developing adults. She presents a very plausible response to their changing needs and status. I use insights from Brennan's account to develop my own theory.

6. Children's rights

What is a right? Two popular conceptions of rights are the choices model and the interests model. On the choice model, rights for adults protect choices over interests. The two may often coincide but on the choices model, I have the right to leave a well-paid and satisfying job, to eat unhealthy food, and to ignore medical advice even when these choices will most likely damage my interests. On the choices model, we can waive our rights. Property rights are a good example. I could waive my right to my property, donating my property to a religious cult or a charity. In contrast, advocates of the interests model claim that rights are inalienable. For example, they claim we do not have the right to duel to the death or to cut off a limb for no good reason (Brennan, p.57). If the interests model is correct, many acts of suicide contravene these rights. For reasons of autonomy, I favour the choices model but am open to the idea that some rights may protect interests.¹⁹

Matthew Kramer uses the existence of children's rights to argue against the choices model.²⁰ His argument runs that children are factually and legally incapable of making reliable choices and thus there are no grounds for protecting the choices that children might make. But this is too fast. Legally 'child' covers the years between 0 and 18. At some point, which will vary from child to child, most children will become 'factually' capable of making reliable choices and the law may take children's choices into account in a number of cases, including choices about custody and choices about their own health. That is not to say that whatever a child chooses will be respected but that the law recognises that, as children develop, so does their capacity to choose. Moreover, the law acknowledges that in certain situations, children's choices are important considerations in determining what should happen to them. That children have interests, and that rights may be one way of protecting these interests, is less contentious, particularly when we consider younger children.

Brennan claims that a failure to appreciate the different role of rights –whether to protect interests or whether to protect choices– has led to an unnecessary impasse in the children's rights debate (2002, 53).²¹ Children do make choices, vociferously,

from a very early age though Brennan concedes that frequently these choices are poorly made. Children's preferences are less stable than adult's preferences and children are unlikely to consider their own longer-term interests adequately, since they do not have enough life experience to imagine how their preferences might change. To Brennan's picture, we can add the insights from the previous section about the variety of influences on children's choices.

We can help children make a successful transition from having their interests protected to choosing well for themselves, and in that way protecting their interests as adults, by educating them now in the art of making choices. Brennan claims that a 'gradualist' account of rights is one in which rights protect interests of babies, infants and younger children, while allowing older and more emotionally and mentally mature children to take certain risks and make their own choices. Parents allow calculated risks when they allow their children to go out unaccompanied, or permit a supervised amount of alcohol consumption in the home before the legal drinking age (Brennan, 61-63). Part of the learning process is allowing children to bear the consequences of their choices but Brennan's gradualist approach also requires that parents re-evaluate the degree of freedoms permitted to reflect the child's progress and ability to make good choices. This minimises the amount of risk to which the child is exposed. Of course, parents are ideally placed, both physically and epistemically, to make decisions about the kinds of risks and choices that will be appropriate to their own child and to fine-tune the degrees of freedom, depending upon the outcomes of previous choices.

Brennan's account addresses the middle of a continuum. At one end of this continuum, children are dependent, irrational and helpless while, at the other end, they have transitioned into adults. According to the choices theory of rights these new adults are autonomous agents, whether or not they have been prepared for this role. Brennan's territory, the middle ground, is "messy but morally important" (Brennan, 65) and she notes that failure to address the moral implications of this middle area has held back the children's rights debate.

Archard and Macleod (2000, 4) note the recent attention to the moral and political status of children has resulted in near consensus that the correct way to view children is on such a continuum as developing adults whose moral status changes as adulthood approaches. In the next section I apply Brennan's findings to the issue of justice in children's healthcare provision.

7. An Asymmetric Theory of Luck Egalitarianism in Children's Healthcare

Part of the value of legally recognising 'childhood' up to the age of 18, regardless of the child's ability to make rational, self-interested choices, arises from the provision of a space within which children can safely make mistakes and learn from them and Brennan's gradualist account illustrates this point. Children need this protected space in order to make the gradual transition from vulnerability and dependency to fully-fledged autonomous agency.

Provision of a safe-space does not mean that children can never bear the consequences of their choices, good or bad. On the contrary, the process of developing more mature and responsible attitudes and choices depends on experiencing the consequences of their actions. However, it is the duty of those who are responsible for children to ensure, where possible, that those consequences are neither too severe nor disproportionate, and crucially that the consequences do not jeopardise the child's progress towards becoming an autonomous agent. Brennan throws light on the complex but neglected area of the development continuum. In a similar vein, I argue that the interaction between responsibility, choices and healthcare for developing children is an important area for discussion and research. Younger and future generations may be the essential ingredient in the development of a sustainable healthcare service in the future.

When we consider the issue of linking healthcare distributions to responsibility, the need for a safe space in which to make mistakes explains why we do not and also should not restrict healthcare services to children on account of their own choices.²² Brennan's gradualist view demonstrates what is wrong about making a child of any age suffer bad health outcomes. The cost imposed is too great a price for the child to bear. Those responsible for the child must recognise that the degree of freedom is greater than appropriate for that child. If the child is putting her health at risk then she lacks sufficient maturity to handle the kinds of choices under her control. Harry Brighouse argues that governments, welfare agencies and parents must recognise make the child's interests central to their policymaking, intervention and parenting respectively.²³

With the child's best interests at heart, luck egalitarianism will never lead us to withhold healthcare services from children but the concept of responsibility is interesting for other reasons. Responsibility is an important capacity to be developed.

Making a successful transition from childhood to adulthood depends on developing the capacity for making responsible choices in various areas. Responsibility for one's health is one of the most important areas to develop not only because of the benefits to the overburdened healthcare system but also because of the obvious benefits for the child throughout her life.

If we are not going to hold children responsible for their choices, one might wonder how my theory is any kind of luck egalitarianism. Luck egalitarianism does not only withhold resources from an agent because of her poor choices. Luck egalitarianism also requires that agents who make good choices retain the benefits that arise from those choices or behaviours. Moreover, as a pluralist theory of distribution of all goods—not only healthcare resources—luck egalitarianism is concerned with enabling genuine choice.

The asymmetry in my theory is to treat good and bad choices differently and the justification for doing so is to foster responsibility as a capacity, rather than to view it as a stick. Clinicians, healthcare distributors, carers and guardians would recognise good choices made by children, reinforcing the message that children have an important part to play in their own health outcomes. In contrast, healthcare provision continues uninterrupted as a safety net to all children, even if their healthcare needs result from poor or irresponsible choices, and regardless of whether the choice is the child's, the parents' or unknown.

Further justification for this asymmetry is as follows: if the choice is the child's, we can recognise that children's developmental stages limit their capacity for good choices. Echoing Brennan's gradualist account of rights, justice requires the recognition that developing responsible attitudes is a work in progress. If the poor choice is the parents', there are two reasons not to withhold healthcare. The first, as mentioned early in this paper, is that placing the burden on the child is to 'punish' the wrong agent. The second is a matter of protecting the child's best interests.²⁴ A costly medical bill for their children's medical care may deter parents from seeking medical help at the appropriate time or at all. In the case of a conflict of interests, we put the children's interests first.

8. Existing Interventions

The luck egalitarian literature proceeds in terms of benefits and burdens. My asymmetric theory protects all children from bearing the burdens of their choices²⁵ and so we need not be concerned that younger children and babies would lose out because of having very little or no capacity for personal responsibility. The focus here is on teenagers, as they approach adulthood. Terms such as 'benefits' or 'gains' might suggest that some prize or incentive should be given to teenagers to reward or encourage responsibility. What kind of positive outcome might encourage or reward such behaviour? I suggest we should be open-minded about this and use this section to explore some existing interventions that follow the asymmetric theory I have outlined.

8.1. Privacy and Attitude: Sexual Health

Clinicians provide contraceptives to under age sexually active minors and protect their privacy from their parents. In doing so, we acknowledge the patient's responsible attitude in seeking out contraceptive advice and we encourage them to return. This is a form of benefit to the teenager in two ways. First, the teenager is protected from sexually transmitted diseases and unwanted pregnancies. Secondly, the teenager is treated with dignity. True, these are also benefits for the healthcare system but that simply adds weight to my suggestion that this kind of intervention will help an overburdened healthcare service. Respect for privacy is a kind of reward for their responsible behaviour.

A second intervention that rewards responsible behaviour is the provision of free chlamydia tests. Although these are needed because of poor choices in the past (unprotected sex) the provision of the test encourages teenagers to take some responsibility for their sexual health. In both cases the provision of the free service, the guarantee of privacy and the clinician's non-judgmental attitude reward and incentivise the child's responsible choices. Naturally, for a child below a certain age, the importance of protecting interests would trump the importance of respecting choice-making capacities, prompting protective intervention rather than provision of contraceptives.

In both cases, my asymmetric theory justifies the fact that healthcare providers would not penalise poor choices despite rewarding responsible choices. This combination of behaviours (providing both a safety net and an incentive) focuses on

teenager's best interests and respects choices of the more responsible teenagers. Therefore, the NHS would rightly provide support, treatment and advice with regard to unplanned pregnancies and sexually transmitted diseases regardless of whether or not the teenager used appropriate precautions.

Support for children, regardless of the kind of choices that they make, must be an important aspect of any account that is to have practical application, since healthcare policy necessarily adopts a coarse-grained and protective approach towards children's mental and physical health. As I mentioned before, parents are ideally placed to apply a fine-grained, individual approach to allowing degrees of risk; healthcare providers are not. Valerie Reyna and Frank Farley (2008) argue for increased protection of adolescents based upon research evidence that in normal development the risk seeking part of the adolescent brain tends to develop faster than the rational and cautious part. Adolescents with good reasoning capacity are still liable to make risky choices in certain conditions (e.g. peer pressure, high temptation).

What of future interventions? Developing successful interventions will be challenging. Providing information is a good start but people often need more than facts. According to Butler et al (2013) providing facts and bringing about a single intervention is insufficient to change adult behaviour. My theory also supports the view that research should focus on designing the best interventions: what types, frequency and duration are most likely to support a sustained change in children's behaviour? In what new ways can a healthcare provider encourage and reward responsible choices in children? Providers should consider the possibility that the best answers to these questions may come from children themselves. For example, Oxleas NHS foundation trust launched a self-help and referral website for young people to cope with mental health issues. Young people designed the service.²⁶

9. Some advantages and disadvantages of asymmetrical luck egalitarian healthcare provision

One advantage of the asymmetric theory is that it allows us to sidestep the epistemic concerns about where to apportion responsibility for children's healthcare outcomes since healthcare is not restricted in the case of bad choices. An advantage of concentrating on the importance of enabling responsibility as a capacity is that we

redirect the focus from the current perturbing shame and blame culture. A longer-term advantage may obtain for the healthcare providers. Complex social factors are the cause of many of today's healthcare conditions. Encouraging and supporting the next generation of adults may tackle one of those factors.

It should be reassuring that in many ways existing healthcare provision would not be significantly changed. We should still provide preventative medicine throughout childhood.²⁷ Children continue to be supported at all stages of childhood. The difference would be an emphasis on recognising and encouraging good choices by children and on their behalf. We need more research to establish which kinds of activities and interventions would incentivise children not only to make good choices but also to recognise their role in doing so and to take pride in their capacity to make such choices.

10. Limits and objections

One concern might be that my suggestion is too optimistic. Where is the evidence that any kind of reward for good choices will lead to better health outcomes for children? Evidence suggests multiple reasons for falling teenage pregnancies but among those reasons is the increased contraceptive use at first intercourse. Healthcare providers cannot influence all contributory factors but it seems plausible to suggest that they continue to influence those factors within their reach.

A second concern might be that my approach is paternalistic. We have a duty to protect children's best interests and my suggestion is not to impose certain interventions on children but rather to foster a capacity of responsibility in them. Where possible, children can be involved in the design of interventions, allowing them a greater stake and a bigger voice.

A third concern could be that as my proposal focuses on choice and responsibility, it punishes failure or encourages victim blaming. However, this is not the case. Poor choices are not punished on my view. But another concern might be that children will not learn from their mistakes. In response, we must remember that carers, clinicians and policy makers have a duty to look out for the best interests of the child. That may necessitate explanation and teaching but it does not license the

withholding of services. As regards victim blaming, I believe that thinking about responsibility as a capacity to be developed illustrates exactly what is wrong with victim blaming. Where that capacity is absent, or underdeveloped, no blame can attach to the victim.

11. Implications of my theory

Several writers have rejected luck egalitarianism claiming that it lacks practical application, particularly in the area of healthcare (Feiring 2008, Fleck 2011). I have identified many epistemic hurdles for the successful application of a luck egalitarian distribution, where biggest problem relates to establishing the extent to which an adult patient is morally responsible for a health condition. The issue of justice for children in healthcare can illuminate the wider debate.

We need to look at responsibility for health in the whole population in a different light and the key to doing so successfully lies in our approach to healthcare for children. Rather than using 'responsibility' as a stick with which to punish agents, we should be thinking of responsibility as a capacity to encourage and develop in the wider population. People are living longer but with much more complex health needs, so interventions that encourage responsibility as a capacity that future generations of adults can exercise will be a huge source of value to health service providers, saving resources and helping budgets. I accept that the timescale for research into successful interventions and implementation of them to yield the saving required may not be fast enough and for that reason, this approach to the distribution of healthcare resources may need to sit alongside another measure, such as redeploying existing revenues or raising further taxes. Even so, investment in interventions that encourage and enable responsible attitudes is an important matter for luck egalitarian justice. Since we may never resolve the epistemic problem, we have an obligation to reduce the instances of patient-caused health conditions as much as possible. Doing so would reduce the instances and extent of unjust healthcare provision. We can start with children.

References

Albertsen, A., (2015), 'Luck Egalitarianism, Social Determinants and Public Health Initiatives', *Public Health Ethics* 8:1, 42–49.

Archard, D., and Macleod, c., (2002). 'Introduction', *The Moral and Political Status of Children*, (Oxford: Oxford University Press).

Arneson, Richard J., (2000), 'Luck Egalitarianism and Prioritarianism', *Ethics*, Vol. 110, No. 2 pp. 339-349.

BBC Radio 4, "Today", 12th October 2015

Brennan, S., (2002) in Archard and Macleod (eds.) *The Moral and Political Status of Children*, (Oxford: Oxford University Press).

Buchanan A, and Ten Brinke J., (1997), 'The long-term effects for children of different parental backgrounds', Joseph Rowntree Foundation. Available at: <https://www.jrf.org.uk/report/long-term-effects-children-different-parental-backgrounds>

Butler, C. C., Simpson, A., Hood, K., Cohen, D., Pickles, T., Spanou, C., et al., (2013), 'Training practitioners to deliver opportunistic multiple behaviour change counselling in primary care: a cluster randomised trial', *BMJ Online*, March 2013 available at <http://www.bmjjournals.org/content/346/bmj.f1191>

Cohen, G. A., (1989), 'On the Currency of Egalitarian Justice', *Ethics*, Vol. 99, No. 4, pp. 906-944.

Denier, Y., (2008) 'Mind the Gap! Three approaches to scarcity in healthcare. *Medical Health Care and Philosophy*, 11:73–87.

Dworkin, R., (2000). *Sovereign Virtue: The Theory and Practice of Equality* (Cambridge, Mass.: Harvard University Press).

Feiring, E. (2008). *Lifestyle, Responsibility and Justice*. *Journal of Medical Ethics*, 34, 33–36.

Fleck, L. M. (2011). *Whoopie Pies, Supersized Fries*. *Cambridge Quarterly of Healthcare Ethics*, 21, 5–19.

Kramer, M.H., Simmonds, N.E., and Steiner H. 00(eds.) (1998). *A Debate over Rights: Philosophical Inquiries* (Oxford: Oxford University Press).

Marmot, M.G., (2010), 'Fair Society Healthy Lives: The Marmot Review', The Institute of Health Equality. Available at <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

Marmot, M. G. and Wilkinson, R. G. (2006). *Social Determinants of Health*. Oxford: Oxford University Press.

Reyna, V.F., and Farley, F, (2006), 'Risk and Rationality in Adolescent Decision Making: Implications for Theory, Practice and Public Policy', *Psychological Science in the Public Interest*, 7(1), 1-44 available at http://www.human.cornell.edu/hd/reyna/upload/2006-Reyna_Farley_RiskAndRationalityArt.pdf

Scaglioni, S., Salvioni, M., Galimberti, C., (2008), 'Influence of parental attitudes in the development of children eating behaviour', *The British Journal of Nutrition* 99/1:S22-5. Available at <http://www.ncbi.nlm.nih.gov/pubmed/18257948>

Scanlon, T. M., (1998), *What We Owe to Each Other*, Cambridge, MA: Harvard University Press.

Scarborough, P., Bhatnagar, P., Wickramasinghe, K.K., Allender, S., Foster, C. and Rayner, M., (2011) "The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006–07 NHS costs" *Journal of Public Health*.

Smith K, Hunter D, Blackman T, Elliott E, Greene A, Harrington B, et al. (2009) Divergence or convergence? Health inequalities and policy in devolved Britain. *Critical Social Policy*; 29:216–42.

Townsend, P., Davidson, N., Black, D. and Whitehead, M. (1988). *Inequalities in Health: The Black Report - The Health Divide*. London: Penguin.

Wikler, D. (1987). 'Who Should Be Blamed for Being Sick?' *Health Education Quarterly*, 14, 11-25.

Wikler, D. (2004). 'Personal and Social Responsibility for Health.' in Anand, S., Peter, F. and Sen, A. (eds), *Public Health, Ethics, and Equity*. Oxford, NY: Oxford University Press, pp. 109-135.

Wolff, J., (1998) 'Fairness, respect and the egalitarian ethos', *Philosophy and Public Affairs*, Vol. 27, pp. 97- 122.

Wolff, J., (2010) 'Fairness, respect and the egalitarian ethos revisited', *Journal of Ethics*, 14:3-4, pp. 335-350

Notes

1. An example from David Cameron: In a speech in Runcorn on 22.6.2015 Cameron expressed the ambition to achieve a move from "low-wage, high-tax, high-welfare society to a higher-wage, lower-tax, lower-welfare society". <http://www.ft.com/cms/s/0/caff39f0-18e3-11e5-8201-cbdb03d71480.html#axzz3qKrfH29X>
2. For an interesting discussion of approaches to scarcity, see Denier, 2008.
3. Chris Hopson, the chief executive of NHS Providers, which represents trusts, quoted in: <http://www.theguardian.com/society/2015/oct/09/nhs-trusts-in-england-run-up-almost-1bn-deficit-in-three-months> accessed 25th October
4. Hughes-Hallett quoting Beveridge during Radio 4's 'Today' programme on 12th October 2015. My emphasis.
5. Examples include television programmes that depict some recipients of welfare and healthcare as responsible for their plight and undeserving of their benefits, such as "Benefits Street" and "NHS: £2 Billion a Week and Counting", in which the programmers compare the cost of gastric band surgery for a morbidly obese patient with the provision of, say, hundreds of inhalers for asthmatic children.
6. Or whatever is being redistributed.
7. See Dworkin 2000, and Cohen 1989.
8. "Option luck is a matter of how deliberate and calculated gambles turn out—whether someone gains or loses through accepting an isolated risk he or she should have anticipated and might have declined" whereas brute luck is "a matter of how risks fall out that are not in that sense deliberate gambles" Dworkin, 2000, 73.
9. Scanlon, 1998, Chapter 6.
10. I approach luck egalitarianism in relation to child healthcare justice from a UK point of view, where the National Health Service struggles under a burden of increasing debt, funding cuts and rapidly increasing demand for services. However, the problems that the NHS faces will be replicated in many other parts of the world, albeit the funding will be different.
11. See Voight, K. 2013, Wikler, D. 1987 and 2004, and Albertsen, A. 2015, for discussions of approaches from philosophy and see Smith et al (2009) who note the move towards responsibility-sensitive healthcare distributions in UK policy from 2003 onwards.

- 12.** Harris, 1995, 148-9
- 13.** Harris, 1995, 152
- 14.** For an alternative view, see Jonathan Wolff's excellent papers on this matter, 1998 and 2010.
- 15.** See Albertsen 2015
- 16.** Townsend et al 1988, Marmot and Wilkinson 2006
- 17.** Albertsen, 2015, 46.
- 18.** See also Marmot et al, 2010
- 19.** The focus of this paper is not on rights *per se* and so I do not offer a justification for this preference.
- 20.** Kramer 1998: 69 in Brennan 2002.
- 21.** I do not aim to explore theories of children's rights in this paper. Others may take a different view on the grounding and purpose of children's rights. However, Brennan offers good arguments for several important points, which inform my interest in justice for children.
- 22.** In terms of medical decisions, clinicians treat patients aged 16 or over as autonomous agents, capable of making their own medical choices, in clinical practice in the UK. Below that age, UK clinicians apply the Gillick competency test, according to which a child under the age of 16 must be deemed mature enough to understand the nature and implications of a clinical treatment or procedure. However, the non-medical decisions that may have led to the child's medical needs are at issue here.
- 23.** Brighouse, 2002, 36.
- 24.** Also mandated by Articles 3 and 24 of the United Nations Convention on the Rights of the Child
- 25.** Of course, children suffer burdens simply by having poor health outcomes. I mean that no child suffers by having treatment for his or her health linked to responsibility for the cause of the poor health.
- 26.** <http://oxleas.nhs.uk/advice-and-guidance/children-and-young-peoples-services/headscape/>
- 27.** Indeed, there may be pragmatic reasons to do so for adults.