THE RESTORATION ARGUMENT
– A CRITICAL DISCUSSION
Summary
This bachelor thesis is intended to critically examine the restoration argument, an argument supposed to help the allocation and distribution of scarce resources within medical and health care. The restoration argument's main appeal, and what its proponents want to show, is that restoration seems to be non-punitive, and a plausible tool that could hold even in a liberal society. However, is this argument really as innocent as it seems? The restoration argument assumes that individuals have a moral responsibility to be prudent, not for their own good but for the third party that might suffer from resources being made additionally scarce, due to imprudent choices made by others. The question to what extent individuals should be expected to have such a responsibility, and whether this responsibility can be justified within a healthcare context, is what this essay sets out to examine.
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1. INTRODUCTION

1.1. The scarcity of health care resources

Within health care in Sweden, resource shortages are a fact, and thus the question of how to allocate and distribute these resources has become a subject of debate. In the Swedish context, the amount of available resources differs between regions and counties, between hospital care and primary care. Within the limits of national guidelines formulated by parliament, decision makers in these particular regions or counties are free to decide the distribution of health care resources. The national guidelines claim, somewhat simplified, that resources earmarked for social and health services are to be distributed according to the needs of the population, and to be allocated where the resources contribute to the highest possible benefit (Socialstyrelsen, E:1; Socialstyrelsen, E:2). Even though it is not entirely clear what this implies in terms of resource allocation, it gives us a clear idea of the aims. We should primarily help those in greater need, and do this efficiently, no matter how this need has come about. National guidelines can be seen as the general principles of the distribution of health care in Sweden, and will hereinafter be called the distributive justice criterion, or, in short, the DJC.

With the condition of scarcity and the need to allocate and distribute some good, whatever this good might be, comes the question of priority setting. Who should be given higher priority for receiving the good? According to the DJC, those who are in greatest need and who we can help efficiently should get help first. However, these are not the only principles suggested to be relevant for the discussion on priority setting. There might be arguments telling us to care for the patient with the highest possibility of recovery, out of strict utility reasons, or to care for mothers and children first, to secure the forthcoming population. Or the arguments might be economic, simply giving care to the patients able to pay for themselves. Another alternative could be to simply draw lots on who to treat first.

Many people would say that if some people have made certain choices leading to ill health, these individuals are responsible for their ill health, and thus they should get lower priority when resources are scarce. For example, people who drink too much alcohol and, as a result of their choice, now need a new liver, should get lower priority than those who need a new liver because of a genetic disposition. That is, self-inflicted illness should be

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1 We are not, for instance, given an especially thorough description of "need" and "benefit".
given lower priority. The self-inflicted illness has, these people would claim, created an imbalance, and it is the obligation of the person responsible to pay her dues and restore the balance through accepting lower priority. If the patient with a self-inflicted illness does not give up her claims to the organs herself, the decision makers should step in and give her lower priority.

In discussing who should get what, and why, lies questions about autonomy versus authority. That is, to what extent should people be free to do as they like, and when should the government step in? The question is not only, as it may seem at first thought, about property and money but also about liberties and rights (Wolff, 2006). The latter question about liberties and rights, as will be shown in this essay, in a sense conflicts with the former about property and money. When choosing a lifestyle that drags along with it an additional need for care, should the patient at hand be allowed the same right to the resources available as a person who follows a healthy lifestyle? If the answer is no, we need to form a justifiable principle for giving people with self-inflicted illnesses lower priority.

One way of justifying such a principle could be to connect personal responsibility to restoration. Self-inflicted, lifestyle-based diseases represent a large proportion (one third) of the ill health that the health care services are confronted with today (World Health Organisation (WHO), 2002). When seeking health care for lifestyle-based illnesses, these patients push other patients aside, denying them access to health care. This should, some claim, impose a duty to restore on those responsible. To restore, for the individual, could be to accept lower priority when ill due to lifestyle-based diseases. The patient with a self-inflicted disease may moreover forfeit a right to healthcare in favor of the patient who have done nothing by own choice to get ill, but if she refuses to do so, society might step in. The individual moral duty would then be enforced by society and be turned in to a legal one. This prioritization argument is named the restoration argument, and was originally proposed by Brian Smart (1994). We should think of the restoration argument as an argument being the ultimate decider of who should have the higher or lower priority. That is, when the DJC has done its job, and we have two patients who are in equal need, and would be equally benefited, competing about the same health care resources, and when one of the patients is at fault of her ill health but does not forfeit her right to the resources, the restoration argument should set in, guiding us to treat the patient who is not responsible for her illness first. The restoration argument might, on the face of it, seem intuitively wrong. However, one reason for believing that it is a justified
argument is that we use arguments of restoration when we correct wrongdoing in civil as well as in criminal law. This might suggest that the argument could be used in the context of health care as well. The function of the restoration argument could be compared with the case of others defense, as being a way of defending the faultless in a prioritization context (Smart, 1994).

However, just because the idea of restoration is used in other contexts of society does not necessarily show that we should use restoration in the context of priority-setting in health care. Furthermore, there are some disagreements within the restoration debate about what choices should induce a duty to restore. Should dangerous leisure activities fall under the restoration argument? Are they comparable to the case of smoking? What about risky occupations, such as firefighting or mining? As we shall see, there are two alternative solutions to these questions, and each carries its own pros and cons.

The first solution refers to social value as distinguishing between the lifestyle choices that induce an obligation to restore, and the ones that do not. In the case of getting ill due to a lifestyle choice that contributes to society, there is no responsibility to restore due to the need for extended care. The second solution refers to reason and the capability to choose rationally. That is, should a person become ill due to her rational choice, she has a duty to restore.

Both solutions exclude some risky occupations from the restoration argument, the first because of the social value connected to these risky occupations and the second because there being some sort of contract between society and its members, saying that receiving lower priority when contributing to society would simply be unreasonable. Having excluded risky occupations from the restoration argument, the question whether some other lifestyle choices could imply a duty to restore, and if the restoration argument is a plausible tool in allocating resources, remains.

1.2. Outline

This thesis sets out to critically examine the restoration argument. The essential content of the essay is collected from three papers by three authors that discuss the restoration argument.

In sections 2.1 and 2.2, I present the reasoning of two proponents of the restoration argument, Brian Smart (1994) and Tom Walker (2010). Stephen Wilkinson (1999), the third author whose paper is examined, opposes the restoration argument, and I have used his reasoning as a contrast to the proponents. Smart and Walker differ in their opinion of
how the restoration argument should be justified. They also differ in terms of what factors make an individual responsible for her lifestyle choices. Aspects of Smart's and Walker's moral approach to the restoration argument thus differ, but both strongly believe that the DJC cannot handle the problem with scarce resources and allocation alone, and that the solution is to be found in a restoration argument.

In sections 3.1 through 3.4, the four main problems found in Smart and Walker's theories are accounted for more thoroughly. The concluding discussion focuses on the responsibility question, since that, during the process of examining the papers, is the question that was found to pervade the entire restoration debate. My conclusion is that if society thinks of some life-style choices as being so bad that they need to be compensated for by receiving lower priority in a priority-setting context, society should prevent its citizens from making these choices in the first place, or impose additional taxes on them. I will argue that the individual should not be held responsible for her own ill-health in a prioritization context within health care. Equal needs should be treated equally. The patient cannot be punished retrospectively for having ill-health due to smoking, for example. If society thinks that smoking should be a reason for receiving lower priority, society should impose additional taxes on cigarettes from the beginning, so that we are all equal when seeking care. The case would then be solved by drawing lots when there are more than one patient competing about the same health care resources, all of them in equal need and who would be equally benefited. This, because it seems reasonable to put the responsibility on society, not the individual as the restoration argument claims, for health care funds that citizens have given society the responsibility to rule upon, by voting, paying taxes and so forth. Since the solution is based on a fixed premise, this is not necessarily my own proposition of health care distribution. The final notes will explain this further.

2. THE RESTORATION ARGUMENT

2.1. Brian Smart

Brian Smart argues in his paper that some type of restoration argument should be used alongside the distributive justice criterion, the DJC, when it comes to allocating resources and deciding who should have higher priority when scarce medical resources are to be distributed.
“The DJC gives us an order of priority between innocent parties. The question is: should the DJC be restricted to allocations involving innocent parties or should it apply to those responsible for the scarcity too?” (Smart, 1994, p. 26)

According to Smart's version of the restoration argument, we have a pro tanto reason to give people lower priority in priority-setting contexts if the individuals are responsible for their ill health and if the behavior that caused the ill health has no (or a low) social value. This is supposed to be a non-punitive and liberal idea, although he seeks to compare restoration with, and draw parallels from it, to restitution and rectification, terms used in corrective justice within civil law.

Now, what 'social value' amounts to is a bit unclear, but it seems to have something to do with, in a broad sense, the utility and disutility of our actions. For example, in his paper, Smart refers to smokers as an example of those who should be held responsible on the grounds of restoration, while firefighters or miners who get injured in the line of duty should not. Presumably, this is because firefighters and miners contribute to society by taking certain risks, while smokers do not.

However, there are at least two problems, both discussed in Smart's paper, with holding smokers responsible, and thus the duty to restore. Many people would say that smokers should not be held responsible, because of the strong addictive component of nicotine in cigarettes. Some would also claim that since society is complicit in cigarette advertisement and sales, the responsibility question gets more difficult. To meet this challenge, Smart proposes that society should stop cigarette advertisements, and that health care services should provide information and preventive programs for smoking cessation. With this completed, people who still choose to smoke should be held responsible for their actions.

Smart assumes that we as individuals can be responsible for certain lifestyle choices and, accordingly, be responsible for restoring any imbalance that follows these choices regarding resources within health care, much in the same way as we can be held responsible for harming one another and for restoring wrongdoing according to civil and criminal law. Many questions come to mind here, such as, where do we draw the line between restoration and punishment? Could it not be so that restoration in itself is a form of punishment, when leading to a societally enforced lower priority? Smart bases his thoughts on the assumption of there being morally better and worse lifestyle choices. Social value is the applicable principle with which we decide who is at fault and who is not. We all have a sense of which actions are morally right and wrong, and this,
according to Smart, implies responsibility. Herein lies yet another problem: Where do we set the barrier between activities that have social value and the ones that do not, and who is to decide? In addition, how do we handle moralizing over one another's lifestyle choices? Is it a task that we could, and/or should, expect from society to decide for us what activities have social value? And is it reasonable of society to ask of its inhabitants to live up to this ideal? We discuss these questions more thoroughly in the following sections.

2.2. Tom Walker

Similarly to Smart (1994), Tom Walker (2010) believes that a restoration argument is needed as a complement to the DJC when facing limited health care resources. He also thinks that the restoration should consist in receiving lower priority when someone has fallen ill due to a voluntary choice. The two authors differ, however, in the question of how to distinguish the ones at fault from the faultless.

Whereas Smart sees social value as the applicable principle to sort out who is at fault and who is not, Walker proposes that rational, well-informed choices should ground responsibility, and then a duty to restore for any harm follows. That is, we should not judge people for having made morally bad choices, as was Smart's solution with social value as the applicable principle in how to decide who should fall under the restoration argument. Simply the fact that a person is aware of what a particular choice leads to, that is, she has all the information needed and is capable of processing the information correctly in order to make a rational choice, leaves her responsible and obliged to restore for wrongdoing. Similar to Smart, Walker assumes that the wrongdoing consists of an individual making choices that contribute to an additional scarcity of resources, resources that would have been there for another person in need had the individual not made these particular choices.

Walker considers the addictive factors of nicotine more than Smart, and questions whether smoking could at all fall under a restoration argument. And while Smart thinks that rock climbing is an activity that has social value because of the character-forming aspect, Walker finds this activity unreasonably risky. Thus, participating in dangerous sports would fall under Walker's restoration argument, while smoking would not. Smoking would fall under Smart's restoration argument, while participating in dangerous
sports would not (Smart, 1994; Walker, 2010). Therefore, ambiguity is clearly found here.

3. THE PROBLEMS

3.1. Are we as individuals responsible?

According to Smart, there are at least two arguments in favor of his version of the restoration argument. The first is that we, in the context of criminal law as well as in everyday life, judge each other as being right or wrong, which would imply a duty to do right and to restore when having done wrong. This type of reasoning he compares with some version of a common-sense moral as well as the moral stands of deontology (Smart, 1994, p. 26). Smart does not explain his stand in any more detail, and the argument seems to be somewhat ad hoc.

The second argument lies in the question of historical fault and self- and others-defense. Smart argues that although damaging oneself is not a crime, doing harm to others is. Restoration, thus, can be compared with others defense. The restoration argument would be society defending the faultless in a prioritization context. The connection between the others defense and historical fault lies in the offender being the one in charge of continuing or stopping the wrongdoing, except from some outside intervention. The historical fault is ongoing for as long as the wrongdoer continues, and this should be taken into consideration. This reasoning, Smart claims, is the same in any case where there is one party at fault and another who is harmed.

My interpretation of Smart is that if we see fault as strictly historical, as a choice once made in the past, and not as ongoing, restoration for the fault would be similar to punishment. However, if we see history as ongoing, with the wrongdoer still able to turn and do right, it would be equal to others defense, and restoring the wrong by facing a lower priority would therefore not resemble punishment in any way. Only utilitarianism, according to Smart, does not consider past, or historical fault, but sees only the future prognosis when forming principles of allocation and prioritization. He compares his own reasoning with deontological thinking and ordinary morality, which seems to be based on common sense (Smart, 1994, p. 27).

To make the argument a bit more concrete, think about the following example. There is an aggressor, an innocent victim, and a rescuer. As an unprovoked attack, the aggressor tries to strangle the innocent victim and, until the life-taking point of the strangling, has
the ability to stop and let the innocent victim live. The rescuer sees that the aggressor is not intending to stop her lethal violation against the innocent victim and intervenes, leaving the aggressor fatally injured. The rescuer manages to stop the aggressor, and helps the innocent victim, though ill due to the struggle, survive (Cf. Smart, 1994, p.27).

The aggressor would, in a health care situation, be the smoker claiming the next set of lungs available, the victim would be the innocent person in need of these lungs, and the rescuer would society using the restoration argument. The strangling would be the smoker setting out to claim the lungs for herself, and the possible cessation of the strangling, an option ultimately in the hands of the aggressor, would be equal to the smoker forfeiting her right to the set of lungs available. When the smoker refuses to forfeit her right to the organs, the restoration argument sets in, guiding the transplant coordinator to rescue the faultless first, even if this means leaving the aggressor, the smoker, to die.

This example, Smart claims, has all the moral ingredients one needs when making a choice in allocating scarce medical resources. And, he continues, if the aggressor, in our case the smoker, does not give up his own claim to the organs in favor of the innocent victim, the non-smoker, of free will, the restoration argument should set in. What the non-smoker should at least get, according to Smart, is restoration back to the status that was the fact for the non-smoker before the conflict between the two arose.

"We now have a non-punitive principle of restitution. It properly belongs to rectificatory, not distributive justice, since it requires those at fault to restore those endangered or harmed to their rightful status quo. It is not punishment, since it is like paying damages in a civil libel suit." (Smart, 1994, p. 28)

How is this to be properly interpreted? Should the smoker completely forfeit his right and be left to die? Since the debt to pay is to restore those harmed to their rightful status quo, that is, the status that would have been the fact if the smoker had never begun smoking, or does it merely mean that he should be given lower priority? Because, in the next prioritization situation, there might be yet another person to compete with, who is not at fault, and who would, if the smoker had never begun smoking, have had the right to all the resources at stake. Or should the smoker just wait for an unexpected addition in donated organs? Smart doesn't say much more about this than that the question may be solved in civil court, or even out of court, referring to the care version not in fact being a crime. The question is then, how much does the crime version resemble the care version?
And, are we really to draw the parallel as close as Smart does if the question is one that can be taken care of outside court?

The others defense comparison in itself is interesting and gives the fault discussion a somewhat more robust explanation, but is this comparison helpful here? Smart might be prone to making this comparison because he wants to show that in addition to historical fault, ongoing fault should count when it comes to allocating resources, that is, to show that historical fault is, in the actual conflict, ongoing in some sense. This is the fact that, according to Smart, makes the individual responsible. The smoker who claims a new pair of lungs while at the same being the one at fault for the additional scarcity of organs is, in fact, up until the critical point, in charge of the outcome, if she is not interrupted by a restoration argument. The smoker, according to Smart, through her negligent behavior, has caused the non-smokers entitled one-in-one chance to a new organ declining to a one-in-two chance. Through the smoker's negligent behavior, she has, in Smart's terms, forfeited her right to equal priority with the non-smoker (Smart, 1994). This last argument by Smart, as I see it, must assume that the smoker should have to wait until there is no one who is not at fault competing for the resources at hand, which seems too harsh and thus counter-intuitive.

Walker's proposal for what gives us reason to hold individuals responsible for their choices, and what choices impose a duty to restore, lies in reason, not social value. Having the capability and the information needed to make a rational choice implies responsibility, according to Walker (2010). It may seem that he escapes some of the problematic features of Smart's theory of responsibility by choosing a more neutral criterion for responsibility. There is a problem, though, which none of the authors have taken seriously. If decision-makers assume some choices made by the individual to be bad, and thus leading to a responsibility to restore some imbalance, should the decision-makers not make these choices illegal? Why should the individual be held responsible for the welfare system for something that could possibly be avoided? Is it really fair of society to lay upon its citizens this kind of responsibility?

The problem that lies in holding individuals responsible for restoring could be handled by altering the responsibility factor to some sort of reasonableness factor and to lay the question of responsibility in the hands of society instead of the individual. What can society reasonably expect from its citizens? Segall (2010) believes that we should not place this kind of responsibility on the individual, as Smart and Walker propose. If what we want to achieve is a greater good for the welfare system, then the responsibility
should instead be placed on the decision-makers. Accordingly, if decision-makers assume some choices are bad, and must be restored for, the decision-makers should simply make these choices illegal, and prevent people from making them. Another alternative is to impose additional taxes on cigarettes that could make up the additional health care costs or to introduce additional health care insurance for individuals who choose to participate in risky activities\(^2\). It seems intuitively wrong that the individual is faced with the responsibility of ensuring society's healthcare system.

**3.2. The epistemic problem**

For decision-makers, the epistemic problem lies in not ever knowing for certain that an illness is, in fact, self-inflicted. Could it not be argued that all illness is, in some way, self-inflicted? For the individual, it is not certain that she knows what an actual choice may lead to. She might not have access to all the information needed to make a rational choice, or she might not be able to correctly process the information at hand.

According to Walker (2010, p. 206), what makes it fair to hold people responsible for the ill health emanating from their actions is the capacity to make well-informed choices. If a person has all the facts at hand, and the capacity to process the information, as well as the capacity to perform the most rational choice, he or she has made a well-informed choice and should be held responsible for it. There is a limit, though, Walker affirms, as to what extent we can be expected to weigh the risks of a particular choice. We cannot be expected to weigh the risks and possible outcomes against each other in every choice we make (Walker, 2010, p. 208).

The epistemic problem is important whenever rational choices are discussed. Is it really possible to have all the knowledge needed to make a well-informed choice at all times? Or at any time? Take a recent example. For a long time, type 2 diabetes was thought to be an illness solely caused by an unhealthy lifestyle, and we can still prevent it through eating healthily and exercising. Furthermore, even when type 2 diabetes is a fact, we can to a high degree keep it under control with the same factors, that is, through eating healthy foods and exercise. However, researchers have found that a gene is involved in developing type 2 diabetes. Some are more likely than others to develop type 2 diabetes (Grant, S. F. A. et. al., 2006).

\(^2\) Walker (2010) proposes the possibility of introducing additional taxes or insurance, but he presumes they are absent when he forms his version of the restoration argument.
Assume that two individuals are carriers of this gene and are diagnosed with type 2 diabetes at the same time and that the health care services can pay for a special diabetes regime for only one of them. Assume further that both individuals have had the gene in question from birth, but only one has had information about it. Should the one with knowledge be given lower priority? She had the information needed. That is, she knew that choosing a healthy lifestyle would decrease the possibility of developing type 2 diabetes, and she had the capacity to process the data at hand, that is, she had the cognitive ability to understand. However, she still chose to eat unhealthily and not to exercise. According to Walker, the answer is yes, she should be given lower priority. It could be that they both had a weakness for sweets, and just could not force themselves to go on a run, but one of them has to be given lower priority, according to the limited resources. With Walker's version of the restoration argument, it has to be the one who knew that she carried the gene (Cf. Walker, 2010, p. 207).

Walker (2010) sees problems with his theory, resembling the case above, as well. In a case of two climbers, where one is using all the relevant equipment, is well informed about the risks she is taking but still gets hurt when falling, and the other climber, incapable of following safety instructions falls, and gets as injured as the first, the first climber should receive lower priority, according to Walker's formation of the restoration argument. That is, she knew what she was doing, and she had made a well-informed choice but still got hurt. This intuitively seems wrong, and so thinks Walker.

"This does not mean that doubts won't remain - we've seen that there will be some cases where it is unclear whether the person's choice caused the illness, and some cases where we don't know what choices they made. But it is important not to overstate this problem." (Walker, 2010, p. 207)

Walker seems to think that the need for a restoration argument balances the dilemmas mentioned. But can we really play the game with such uncertain rules? Is it not best to be humble and accept that the epistemic problem is serious? If we are to settle for a restoration argument of Walker's type, we must also be prepared to pay back when we make mistakes. However, the question is if it is even possible, considering the damages that could already be a fact when the mistake is revealed. It could be claimed that we are always faced with some uncertainty in all our choices and that we must always be prepared to rethink the prioritization order, but if we, already in theory, can identify the problems this clearly, it would seem to be a strong objection against the restoration argument as formed by Walker.
Priority-setting according to the DJC alone could result in similar problems. Decision-makers could be wrong to assume that one person's need is greater than another's; they could be forced to admit that they made the wrong priority. In my opinion, though, this would not have moral consequences of the same degree as when using the restoration argument, because the decision-makers would have based their decisions on some 'objective conclusion', or mutual agreement, of benefit and greater need when following the DJC, not on choices made by the individual, as when following the restoration argument. However, the question of whether it is plausible, or even possible, to agree upon objective values such as greater need or benefit, and how they are to be measured, is still being debated (Cf. Brülde, 2003, pp. 135-165). Should the preferential choice be grounded on expected life years for the patient? Or on expected productive life years? Or on expected quality of life? And how is this to be defined, or measured, objectively? Thus, following the DJC alone could result in ambiguity and may not be the optimal solution for all cases, but it would avoid the difficulties with the epistemic problem connected to individual responsibility of the restoration argument.

3.3. Social value as moralizing

Smart (1994) confesses that there are problems with using social value as the applicable principle when deciding who is at fault and who is not. However, similar to Walker's reasoning regarding the problems of his theory, Smart thinks it important not to overstate these problems. The need to form a restoration argument as a complement to the DJC, both authors reason, outweighs theory-related problems.

According to Smart, the problems with his version of the restoration argument lie in separating the activities that have social value from the ones that do not. Smart assumes that smoking does not have social value, while rock climbing does, the latter because it gives a feeling of achievement as well as forming a good character. The social value of smoking, however, Smart claims, is just an illusion.

Social value, thus, is an ambiguous term. It is not entirely clear how we should separate what is socially valued or valuable from what is not. The question is, is it at all desirable, or even possible, to form an objective criterion of social value? Stephen Wilkinson, who opposes the restoration argument, argues that using social value as the applicable principle in sorting out which choices imply fault from the choices that do not, as does Smart, involves an unacceptable moralizing aspect. Whereas Smart intends for social value to distinguish between those at fault and those not, to make the restoration
argument liberal and non-punitive, Wilkinson claims that within the very use of social value as an applicable principle lies the punishing and non-liberal aspect of the restoration argument. When explaining his opposition, Wilkinson refers to John Harris, another opponent of this argument, who says that letting one person be worse off, or even die, due to some moral defect in her personal traits is letting the decision-makers capitalistically punish immorality (Wilkinson, 1999, p. 265). However, think about the case of an individual born with heart failure, and another individual who has made certain choices leading to heart failure. Who should be given the only heart transplant available? The intuition might go for the faultless person here. Another solution would, of course, be that the state imposes taxes on behavior that may lead to heart failure, which would give the two individuals an equal opportunity to the only heart transplant available. The case would then, presumably, be solved by drawing lots.

The problem with using social value as an applicable principle lies in the government's control over citizens, according to Wilkinson. He opposes the moralizing over individuals' lifestyle choices and the assumption that one choice can be objectively more valued or valuable than another. He makes a distinction between Smart's social value as either valuable or valued, and rejects both interpretations. Social value as valuable (having utility value), because it leads to a 'majority tyranny', that is, we cannot leave to the majority to decide what a decent lifestyle should be and to discriminate against individuals who diverge from it. To do so would be to claim that unless you contribute to society, your actions are worthless. Social value as valued (appreciated), he rejects because of its practical arbitrariness. That is, who is to decide what activities have objective value, and how is it to be decided? Is there something we can call objectively valued? If we set the government to decide what activities its citizens could engage in and not, it would lead to unfair bias and discrimination, according to Wilkinson (1999). With Wilkinson's reasoning, though, one might wonder if we can even decide upon the greatest need, or highest possible benefit, as the criterion for the DJC, since these criteria also seem to be based on some sort of value appreciation. It might be so that even the principles behind the DJC are too arbitrary.

Areas where we find mutual agreements on value, what to strive for, and so forth, are within corporations, other workplaces, and schools, for example. If we could come to a mutual agreement on such values to strive for within society, perhaps that would make a positive contribution to welfare, and thus keep down health care costs, for example, if we all tried to keep ourselves healthy because of a mutual agreement on the value of ensuring
public health. However, the question of whether diverging from these common values should have some sort of punishment, or some duty to restore, attached to them remains.

3.4. Is restoration punishment?

If there were enough resources, fault would never become a question of debate. However, even with the situation of facing scarce resources within health care, there are many voices, in particular from medical professionals and moral philosophers, saying that, even if we face scarce resources, we cannot blame people for choices they made in the past, we cannot punish people for their past actions.

Opponents of the restoration argument claim that even though it might be plausible to assume that we all have a duty to promote and encourage morality, in the sense that we try to do good, that fact does not make it our right to punish immorality. Letting someone be worse off due to a lack of morality, due to a defect in the person's character, would mean allowing decision-makers within healthcare allocation to practice capital punishment against that person (Wilkinson, 1999).

Smart believes that the restoration argument is liberal and a question of corrective justice, not punishment. He explains this with the idea that the historical fault is ongoing, as explained in section 3.1. What the restoration argument sets out to do is simply to restore the balance to the status quo, in Smart's opinion, but as we shall see, other philosophers, such as Wilkinson, argue that there is a noticeable resemblance between restoration and punishment (Smart, 1994, p. 27). In addition, as shown in section 3.1, Smart cites examples that compare rectification in crime with restoration in health care.

If we draw a parallel to the crime debate, as Smart does, harsh threats and punishment often seem to be counterproductive (Braithwaite, 1989). This could be the case in the health care debate as well. For example, if a person chooses to smoke, knowing that being a smoker implies she will receive lower priority when she gets ill, she might also choose not to exercise or to drink excessively. This line of thinking might actually be the same for individuals in health care contexts as well as in crime contexts. If a person is furious about her partner's lover and shoots the lover in rage, she might as well shoot another person she is mad with or rob a bank, knowing that either way she will be locked up for life. Smart, at the end of his paper, acknowledges this problem but dismisses the argument with the response that if we had a distribution system that was equal for all no matter what, people would tend to be less cautious about their health. That is, the opposite of what has been shown in the crime debate. It is well-known that harsher
punishment does not lead to lower crime rates, and, plausibly, being punished for not being prudent considering one's own health would not lead to an attempt to live healthily. My guess is that Smart's reasoning here originates from his common-sense and deontology-based moral stands. Paying back, or doing your duty, becomes more important than the actual outcome of such rules. However, decision-makers making certain activities illegal or impose additional taxes, as was my proposed solution to the problem in section 3.1, has proven to be efficient in crime contexts. An assumption is that similar constraints could be useful instruments within health care contexts as well. Thus, laying the responsibility on society to make these activities that are assumed to increase health care costs illegal, or impose taxes on them, may actually lead to people not making these choices in the first place, and thus, people will not need to be punished retrospectively.

"...the restoration argument is a 'moralising wolf in a liberal sheep's clothing'."

(Wilkinson, 1999, p. 265)

Wilkinson claims that the restoration argument, as formed by Smart, is a form of punishment. It deters people from making certain lifestyle choices by threatening individuals with sanctions. It rewards people who are prone to live what is objectively seen as good living, and promotes the same. The restoration argument is not, as Smart claims, a liberal, non-punitive argument but the opposite, Wilkinson states (1999, p. 266).

Either way, I assume that the solution is to be found in changing the question of who is responsible from the individual to society. Society should be responsible for imposing reasonable limitations or taxes for activities it finds too expensive in terms of health care costs since the welfare and health care fund is a fund that people have put in the hands of society to rule upon to ensure public health.

4. CONCLUDING DISCUSSION

Should individuals be held responsible for decisions that lead to ill health and thus scarcity regarding resources in health care? Smart's response, which is somewhat ad hoc, refers to common-sense morality and deontology, in that we all have a sense of right and wrong, and that implies a duty to restore when someone has done wrong. It resembles an 'eye for an eye' reasoning, where the wrongdoer must restore the balance to the status
This might hold as a method of reasoning in the crime debate, but the question is, should decision-makers of society really place this kind of responsibility on the individual within the health care context? And if we assume that the restoration argument is a plausible complement to the DJC, what lifestyle choices should impose a duty to restore? It seems that various philosophers have come up with different, and sometimes completely incompatible answers, as seen with Smart claiming smoking should be restored for and Walker assuming not. Thus, there is an ambiguity, in terms of how the duty to restore should be justified, by social value or by rational choices, and regarding what choices have social value, or are rational and well informed. The two problems seem to follow each other. Smart and Walker, however, think that we should not overstate the problems with the restoration argument. The need for such an argument as a complement to the DJC, they claim, outweighs the complications.

A strong argument against Smart's attempt to justify individual responsibility is that basing principles of distribution on common-sense, or everyday morality cannot suffice. Walker's individual responsibility solution is also insufficient. We cannot have a society that blames either individual immorality or individual irresponsibility when the choices are legally there for people to make. If we draw a parallel to the increasing deficits of the welfare system in Sweden, people who are not familiar with political and economic patterns, tend to blame groups of individuals, such as immigrants, for the shortage, when the problem is really situated elsewhere, in too low taxation or incorrect budget distribution. The danger in putting the responsibility for ensuring health care resources on the individual, on the grounds that Smart and Walker propose, is that it may lead to splitting people within society, and to separating 'good' people from 'bad'. Basing principles of prioritization on individual responsibility by using common-sense morality, or deontology, in the sense used by Smart, as the shaping tool, would simply not fit in a decent health care system. It would lead to discriminating against certain groups of individuals.

The optimal solution to the problem of scarce resources within health care, one might think, would be to allocate more money to health care services from the beginning. However, as the health care status of society improves, higher standards of health care will be set, with higher costs following. Thus, if this is not a possible sole solution to the problem of scarce health care resources, and if decision-makers assume that some lifestyle choices (such as smoking) are so bad that they lead to a duty to restore, why not
simply make them illegal or impose taxes on them from the beginning so that the individual does not have the obligation or responsibility to pay back afterward. This would partly lead to society being somewhat paternalistic, but it would relieve citizens from the risk of being retrospectively punished for previous lifestyle choices. This solution could also solve the government complicity in advertising and providing the goods. However, it is easy to imagine possible problems with making certain lifestyle choices illegal, or imposing additional taxes; it could easily lead to unfair bias and discrimination. Nonetheless, it would be a better solution than punishing people retrospectively.

To place responsibility upon the individual, as the restoration argument urges, from either the social value principle, as stated by Smart, or the rational choices principle, as formed by Walker, seems unreasonable. This partly because it is a huge responsibility to bear, but also because the available resources within health care are a common fund of society, and thus, the responsibility of society, not the individual. What we are left with is to leave the responsibility to society, not to form an objective principle out of social value, since that would be to punishing immoral behavior, but to figure out what society can reasonably expect from its citizens. If society cannot reasonably expect people not to use tobacco, but still consider the effects of tobacco use an economic burden on society in terms of health care costs, society could impose higher taxes on tobacco from the beginning. The same reasoning goes for rock climbing or other risky activities. This reasoning is also in agreement with Segall's thoughts, explained in section 3.1 (Segall, 2010).

The restoration argument from a physician's point of view is a theme that none of the examined papers have accounted for. Without having examined the question closer, we could assume, based on physicians' basic ethical standards, that the restoration argument would not seem justified in a health care context. For example, physicians in Sweden, as well as in all member countries of the United Nations (UN), have an obligation to treat prisoners the same as all other citizens who seek care. How would these physicians explain, or even handle the absurdity of giving a smoker lower priority based on the smoker making a morally questionable choice, while giving prisoners, some of whom might be imprisoned for having taken another person's life, full access? Note that I am not arguing that the prisoner is not entitled to his fair share of health care. I am just
pointing out an absurd implication of the restoration argument (Cf. Svenska läkarsällskapet, SLS, E:3).

5. FINAL NOTES

Securing public health is, and should be, an important question for society. Individuals' capacity to live a decent life, engage in social activities, and even contribute to society depends on their health status. Introducing a restoration argument in health care priority-setting could make securing public health more difficult. Until the summer of 2013, we had, in Sweden, people blamed for having made the wrong choices, people who the health care system refused to help and who had to confide in healthcare personnel who voluntarily, with no payment and against the law, set out to help them. These people to whom our society refused to provide care were the growing number of unregistered immigrants. Similar judgments have been made, in Sweden and elsewhere, about homosexual persons during the HIV and AIDS outbreak, for example. It is easy to imagine the potential practical effect that were to come if we were to use a restoration argument together with the DJC, that, with decreasing resources, society might end up sorting out group after group of individuals.

The reasoning in the concluding discussion is based on the premise that society assumes some lifestyle-choices to be so expensive that they should be restored for, a premise that is elementary for the restoration argument. While working with the essay, I developed my own stand in the question. In my opinion, the restoration argument is an implausible tool altogether. Even if the restoration argument is assumed to be the final decision, the last argument to decide who to treat first when resources are scarce, the moral problems with using such an argument outweighs its advantages. When two patients, equally ill and with an equal prognosis, seek care, they should have an equal right to health care no matter how their need of health care has come about. In the crucial decision of who to treat first when resources are scarce, decision-makers should not use an argument of restoration. This since it could be claimed that all illnesses are in some way self-inflicted, and that we are, in most cases, faced with some uncertainty regarding whether the actual condition was caused by the patients lifestyle-choice (except from traumas like falling from climbing for example). We can for instance never know for sure that a patients heart or lung condition is due to her smoking exclusively, or if she would have got sick anyway. And even in the few cases that we do know for certain, I do not think it to be a task for the decision-makers of health care to moralize over peoples life-
style choices in the crucial rescuing point. We simply do not have knowledge about all the surrounding circumstances.

To take an example from my own experiences as a nurse at neurosurgery, at one specific period, we got several young patients with traumatic brain injuries from having surfed rooftops of cars for enjoyment. These patients had clearly made choices leading directly to their ill health. The restoration argument would claim that in the crucial decision of prioritizing, they should receive lower priority than a person who has driven on an icy road and hit a tree, for example. We can imagine the problems that would follow a prioritization decision like this; How would we explain to the parents of the young patients that we prioritized down their children on the basis of their voluntary engagement in dangerous activities? And do we know to what extent their actions were in fact voluntary? Where there drugs involved? And if so, does that make their decision less voluntary? Or could the restoration argument claim the risky activity to be even worse due to the possible drug use? With all these questions, an arbitrariness follows the decision making, which would lead to the option of simply drawing straws about who to treat first being a more morally justified tool of prioritization than the restoration argument.
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