Will Responsibility Save the Day? In Defence of Responsibility-Sensitive Discrimination in Healthcare

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Will Responsibility Save the Day? In Defence of Responsibility-Sensitive Discrimination in Healthcare

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To my little sister, Iris.
For all the moments you missed me because I was lost in my PhD,
and for still being there in all the ways that truly mattered.

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Ὅσο μπορεῖς
As much as you can

Κι ἂν δὲν μπορεῖς νὰ κάμεις τὴν ζωή σου ὅπως τὴν θέλεις,
And if you can't shape your life the way you want,

τοῦτο προσπάθησε τουλάχιστον ὅσο μπορεῖς:
at least try as much as you can

μὴν τὴν ἐξευτελίζεις μὲς στὴν πολλὴ συνάφεια τοῦ κόσμου,
not to degrade it by too much contact with the world

μὲς στὲς πολλὲς κινήσεις κι ὁμιλίες.
by too much activity and talk.

Μὴν τὴν ἐξευτελίζεις πηαίνοντάς την,
Try not to degrade it by dragging it along,

γυρίζοντας συχνὰ κ' ἐκθέτοντάς την
taking it around and exposing it so often

στῶν σχέσεων καὶ τῶν συναναστροφῶν τὴν καθημερινὴν ἀνοησία,
to the daily silliness of social events and parties,

ὡς ποὺ νὰ γίνει σὰ μία ξένη φορτική.
Until it comes to seem a boring hanger-on.

Κ. Π. Καβάφης, 1913
C. P. Cavafy, 1913

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People sometimes say that a PhD is like a marathon race. It takes courage, consistency, endurance, a strong sense of self-discipline and perseverance, strategy, and, of course, a supportive network of people to successfully cross the finish line in both cases. So, just before crossing my own finish line, I need to thank all those people who inspired and encouraged me to keep up the hard work long before starting this PhD project, and all those colleagues, friends, and family who, through their support, made it possible for me to survive and even enjoy this challenging but priceless and unforgettable journey.

As a brief disclaimer, I should mention that I am breaking with convention in these acknowledgments by beginning with my family rather than ending with them. You will also notice that, at certain points in both the dissertation and these acknowledgments, I include some text in Greek. I promise that an English translation will always follow, so that we are all on the same page!

Μαμά και Μπαμπά, δε θα στεκόμουν σήμερα εδώ χωρίς εσάς! Σας είμαι βαθύτατα ευγνώμων για όλα αυτά που μου διδάξατε· να είμαι πειθαρχημένη και εργατική, ηθική και ευγενική, επίμονη και λίγο πεισματάρα (χρειάζεται όταν κάνεις διδακτορικό!), να δείχνω σεβασμό, να είμαι αληθινή και να μη φοβάμαι να αδράξω κάθε ευκαιρία που εμφανίζεται στο δρόμο μου. Μπαμπά, σε ευχαριστώ που έθεσες τον πήχη τόσο ψηλά. Δεν θα ήμουν ο άνθρωπος που είμαι σήμερα, ούτε θα είχα καταφέρει όλα αυτά χωρίς εσένα και την ακούραστη έγνοια σου. Μαμά, σε ευχαριστώ για τη σιωπηλή αλλά αδιάκοπη στήριξη σου, που ήταν πάντα εκεί χωρίς να χρειάζεται να ειπωθεί τίποτα. Σε ευχαριστώ για το χώρο που μου δίνεις να είμαι ο παραπονιάρικος εαυτός μου, για όλες τις εκτενείς βιντεοκλήσεις μας αργά το βράδυ και για την υπομονή σου κάθε φορά που είχα ανάγκη να μοιραστώ όλα αυτά που με άγχωναν. Ένα ιδιαίτερο ευχαριστώ, όμως, οφείλω στην αδερφή μου, Ίριδα! Σε ευχαριστώ για την απροϋπόθετη αγάπη σου, το θαυμασμό, την πίστη σου στις δυνάμεις μου, και όλες τις μικρές και μεγάλες συζητήσεις μας για τη ζωή. Είσαι ο καλύτερος συνοδοιπόρος που θα μπορούσα να ευχηθώ!

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Finish Time? Although the clock reads 3 years, 2 months, and 14 days, my true finish time should be measured in the relationships, the growth, the opportunities, and the quiet inner shifts that will stay with me long after this race is over.

Thank you all for making this journey truly unforgettable!

Lydia
Aarhus, November 2025

Preface

The following report provides a summary of my PhD dissertation titled 'Will Responsibility Save the Day? In Defence of Responsibility-Sensitive Discrimination in Healthcare'. The dissertation consists of this summary report, a co-authored chapter in an edited volume, and three single-authored original papers, which I refer to from now on as co-authored chapter, and Papers A, B, and C:

> **Co-authored chapter**: Albertsen, A., & Tsiakiri, L. (2023). Equality of Opportunity for Health: Personal Responsibility and Distributive Justice. In M. Sardoč (Ed.), *Handbook of Equality of Opportunity*. Springer. https://doi.org/10.1007/978-3-319-52269-2_86-1
>
> **Paper A**: Tsiakiri, L. (2025). Why a responsibility sensitive healthcare system is not disrespectful. *Medicine, Health Care and Philosophy, 28*, 315-325. https://doi.org/10.1007/s11019-025-10262-x
>
> **Paper B**: Tsiakiri, L. (in press). Responsibility-Sensitive Healthcare Policies and Golden Opportunities: (Harmfully) Discriminatory or Not? *Journal of Medicine and Philosophy*.
>
> **Paper C**: Tsiakiri, L. Differential Treatment on the Basis of Self-Inflicted Traits: Is Perceived Wrongful Discrimination Responsibility-Sensitive? (Under Review).

The aim of this summary report is to introduce the overall research question, theoretically and methodologically contextualise my discussions, and shed light on the ways the particular papers are tied together. Additionally, the summary report presents and reflects on the main arguments and results with which I extensively engage in each of the dissertation's papers and highlights the project's (broader) contributions and the relevant avenues for future research.

Chapter 1: Introduction

The scarcity of healthcare resources has been well-documented in both the developed and developing worlds. For instance, according to the Global Observatory on Donation and Transplantation, only 10% of global transplant demand is being met annually (The Lancet Editorial, 2024). Along similar lines, the World Health Organization (WHO) predicts a global shortage of 11 million healthcare workers by 2030, with low- and lower-middle-income countries being the most affected (WHO, 2025). Additionally, during the recent COVID-19 pandemic, the surge in hospital admissions highlighted the insufficient availability of ICUs and ventilators. Later, vaccine production also proved inadequate to meet global health needs. In this context of scarcity, demands for efficiency, cost-effectiveness, and maximising results with limited resources often lead to differential treatment against certain groups. For example, during the pandemic, when only one ICU bed was available and two patients would benefit from it, doctors would usually prioritise the younger patient with a higher chance of recovery. Consequently, healthcare systems and professionals operating under scarcity conditions may systematically deprioritise members of groups, like older people or people with disabilities, since they are expected to require more resources, their chances of recovery and survival are considerably lower, and their lifespan after the intervention is considered significantly shorter.

This pattern of differential resource allocation inevitably raises ethical concerns. For example, is the imposed harm on patients and the implied disrespect justified? And what about the societal implications of such patterns? These and similar concerns converge on the broader issue of whether such treatment constitutes discrimination, which in its most generic definition is the disadvantageous differential treatment of the other who is (perceived as) the member of a socially salient group that has or is believed to have some particular features that are absent from a better-treated comparator (Lippert-Rasmussen, 2013).

The potentially discriminatory dimensions of allocation criteria like age and disability have already been extensively discussed in both pandemic and non-pandemic circumstances, with scholars arguing both for and against their consideration (Jecker, 2022; Wasserman et al., 2020; Wilkinson et al., 2020; Daniels, 2016; Scully, 2020; Lloyd-Sherlock et al., 2022; Gaurke et al., 2021). However, this dissertation focuses on a different allocation criterion, personal responsibility for one's health-related behaviour that contributes to one's

neediness, which the current reality seems to bring to the forefront of the allocation discussion. More specifically, non-communicable diseases (NCDs), such as diabetes, cardiovascular disease, and cancer, are currently responsible for 74% of the global death toll (WHO, 2024), while the subsequent costs and resource demand impose a considerable strain on the healthcare system. Provided that modifiable, individual health-related behaviours, such as smoking, excessive alcohol consumption, and a sedentary lifestyle, determine risk factor exposure, it seems fair to suggest that individuals could, at least to some extent, take responsibility for their health by adopting healthier habits.

With that in mind, over the last 15 years, personal responsibility has been increasingly invoked as the decisive criterion for determining who should be excluded, rejected, or deprioritised under conditions of scarcity. To mention only a few illustrative examples, a 2012 Guardian article reported that a survey found 54% of British doctors thinking that the National Health Service (NHS) should have the right to withhold non-emergency treatment from smokers and the obese (Campbell, 2012). Moreover, in Boston and Colorado, patients in critical condition were denied transplants because of being unvaccinated (Joseph, 2022), whereas in Texas, factoring in vaccination status for ICU triage decisions was proposed during the COVID-19 pandemic (Zornio, 2021). In response to these initiatives, however, others raise concerns about discrimination, emphasising how unlawful and morally unjustified they are, and even advise against them (Lucas, 2012; Reuters, 2022; Cruz-Maxwell et al., 2021). Therefore, the question posed regarding the personal responsibility criterion is once again whether differential treatment on those grounds eventually constitutes discrimination.

The above sentiments echo the long-standing conflict between luck egalitarians and their opponents. Luck egalitarianism – the main theoretical framework of this dissertation – constitutes a responsibility-sensitive theory of distributive justice which suggests that it is bad if some people are worse off than others because of factors that lie beyond their control and argues that the state should be interested in exclusively remedying that kind of inequality (Dworkin, 1981; Arneson, 1989; Cohen, 1989; Roemer, 1993; Rakowski, 1993; Knight, 2013; Lippert-Rasmussen, 2016). However, both the theory and any attempts to apply that to real-life conditions have received extensive criticism regarding, for example, the difficulty of attributing causality (Marmot et al., 1991; Marmot, 2005; 2015; Feiring, 2008; Andersen & Nielsen, 2016; Levy, 2019); the potentially harsh treatment of the imprudent (Fleurbaey, 1995; Anderson, 1999); and most importantly for this dissertation, the formulation, perpetuation, and even amplification of discriminatory dynamics (Cavallero, 2011; Anderson, 1999; Albertsen & Tsiakiri, 2023; Tsiakiri, 2025). This

ongoing discussion underlines the gap in the literature that my dissertation aims to address.

1.1 Research Question(s) and Central Argument(s)

Building on the above, the overarching question of this dissertation is the following: *What should the role of personal responsibility be, and how is it perceived regarding assessments of (wrongful) discrimination?* This broad research question (RQ) could invite a number of different discussions. For example, among others, under the same research question, a dissertation about discrimination on the grounds of religion, one about the role and justifiability of reaction qualifications in the context of employee recruitment, and one about discrimination concerning gender reassignment could all have equally taken place. Thus, to situate myself and the current piece of work in this universe and narrow down my focus, I also propose the following sub-research questions:

- RQ1: To what extent should responsibility-sensitive healthcare resource allocation be considered (wrongfully) discriminatory?
- RQ2: Is perceived wrongful discrimination responsibility-sensitive?

Before outlining briefly which sub-research question and how each of the dissertation's papers addresses, the role of these questions in this summary report and the dissertation as a whole should be clarified. First, on a more general note, they enhance the summary report's clarity and structure, pointing out how the papers are tied together and that they address the same core question, merely commencing from different methodological angles. In addition to that, they most importantly specify the scope and the focus of the dissertation. They show how I narrow down the overall RQ, what dimension of that I actually address and measure in my papers, the level of analysis each of my papers adopts – normative, empirical, or both – and the domain in which the discussion is situated. To illustrate that, an examination of the role of personal responsibility regarding assessments of (wrongful) discrimination includes a question about how the former influences the latter, under which conditions, in which contexts, and so on. However, the proposed sub-research questions clarify that I exclusively address and measure whether the presence of personal responsibility for a trait can mitigate our concerns about the occurrence of wrongful discrimination when people are treated differently on those grounds. Furthermore, they also indicate that my discussion takes place at both the normative and empirical levels. I begin by developing normative arguments and then examine whether these arguments are reflected in laypeople's perception of wrongful discrimination through empirical studies. Finally,

the sub-research questions highlight my focus on the healthcare domain. I will explain the rationale behind this choice below.

To situate each of the dissertation's papers in this context, let me note the following. First, the co-authored chapter extensively engages with the discussion surrounding the role of personal responsibility in distributive justice in general and in the healthcare context more specifically as perceived under luck egalitarianism. The chapter provides some of the preliminary distinctions discussed later and contextualises the rest of my discussion theoretically. Most importantly, it is the one that introduces and elucidates the critique of discrimination that was recently raised against considering personal responsibility as a scarce healthcare resource allocation criterion, emphasising the gap/controversy in the literature addressed by the rest of the thesis.

Moving on, Paper A defends a responsibility-sensitive healthcare system against the respect-based group of critiques: the harshness, intrusiveness, and discrimination critiques. I will elaborate on those critiques in my next chapter, but in brief, each one interprets in its own way how such a system disrespects those responsible for their current poor health condition. By invoking arguments from the deontological tradition, Paper A engages with the normative discussion about whether responsibility should be used as a criterion for allocating scarce healthcare resources from a respect-based perspective. Addressing RQ1 directly, it ends up suggesting that a responsibility-sensitive healthcare system creates the required conditions, so that (self-)respect is preserved and promoted instead of undermined as the critiques argue.

Paper B assesses how certain types of responsibility-sensitive healthcare policies would fare against the most prevalent understandings of (harmful) discrimination. It meticulously examines whether these types of policies adhere to seminal definitions of non-moralised and harmful discrimination and their conditions, while invoking a McMahanian argument in their favour. In this context, Paper B directly addresses RQ1, ultimately advocating for more moderate applications of the responsibility-sensitive mindset, at least in relation to concerns about discrimination. Once again, this paper engages with the normative question of whether personal responsibility should be considered regarding the allocation of scarce healthcare resources, albeit at a more applied level than Paper A.

Finally, Paper C examines laypeople's perception of wrongful discrimination when personal responsibility for the targeted trait is present, focusing on healthcare resources and welfare benefits allocation. To illustrate this, this paper tests whether the theoretically formulated arguments in my theoretical papers and co-authored chapter are reflected in laypeople's perceptions. Moreover, Paper C directly addresses RQ2 through empirical studies and ultimately suggests that laypeople indeed adopt a responsibility-sensitive understanding

of wrongful discrimination, classifying cases of differential treatment based on a chosen trait or condition as more justified or even completely acceptable. Variations in people's responses under different conditions are, of course, detected, but they do not question the general pattern.

Therefore, building on all the above, the overall and central arguments of this dissertation are that:

1. from a discrimination-based point of view, responsibility-sensitive healthcare resource allocation should be considered justified, especially under moderate measures; and
2. that perceived wrongful discrimination is responsibility-sensitive since the presence of responsibility for the targeted feature is proven able to significantly reduce the extent of perceived wrongful discrimination on those grounds.

1.2 Case Selection

In my dissertation, I discuss the relationship between personal responsibility and wrongful discrimination concerning, mainly, the health(care) case. There are multiple reasons behind this case selection. First, both classic and contemporary luck egalitarians often invoke health-related examples to illustrate how their abstract theoretical claims would be implemented in real-life conditions, implying that health(care) is a case worth considering in this context. For instance, Ronald Dworkin (2000) argues for the plausibility of insurance companies charging cigarette smokers and mountain climbers higher premiums due to their engagement in risky habits. More recently, Shlomi Segall (2010) dedicated a whole book to the discussion about *Health, Luck, and Justice*. Yet, most of the criticism raised against this viewpoint targets its health-related suggestions and applications, underlining that health(care) is a difficult case and that serious consideration of the role of personal responsibility in this context is required. Adding to that, health(care) constitutes a crucial case given the intrinsic and instrumental value of health and the fact that decision-making in this context considerably affects every one of us.

To illustrate the above claim, it probably suffices to say that health is perceived as a good in itself with intrinsic and consequently inalienable value, and because of that, it is preferable at all costs. But what happens when not everyone can access the healthcare needed to preserve or restore their health while they bear some extent of responsibility for their current state of need? Along similar lines, Norman Daniels illustrates health's instrumental value when he cites the example of 'an unlucky skier who has broken his leg and our subsequent obligation to fix it simply because the skier cannot function normally if we do not' (Daniels, 2008, 76). But again, what happens when not everyone can access the healthcare needed for the restoration of their health while

bearing some responsibility for their current state? The importance of a response to these questions and the implications that this would have for every single individual highlight the relevance of health(care) as the focal case of my dissertation.

1.3 Outline

The rest of the summary report develops as follows. In Chapters 2 and 3, I theoretically and methodologically contextualise my discussions. In essence, Chapter 2 engages with the core theoretical pillars of my dissertation, i.e., the discrimination theory and luck egalitarianism. Similarly, Chapter 3 unpacks the methodological approaches invoked throughout my PhD project, i.e., analytical philosophy and the tools of reflective equilibrium and thought experiments, and experimental philosophy (X-Phi) with a specific focus on the more nuanced trajectory of experimental philosophical bioethics (BioXPhi).

Then, the remainder of the summary report is structured by the three papers of the dissertation. Chapter 4 presents the key deontological arguments of Paper A raised against the respect-based critiques of a responsibility-sensitive healthcare system, clarifies how this paper addresses RQ1, and reflects on aspects of the paper worthy of further consideration. Chapter 5 engages with Paper B, examining to what extent certain types of responsibility-sensitive healthcare policies adhere to seminal definitions of non-moralised and harmful discrimination, and clarifies how this paper addresses RQ1. Chapter 5 also reflects on specific aspects of this paper's discussions, such as the different understandings of responsibility and the fundamental problems that some of these types of policies face. Chapter 6 engages with Paper C, the experimental philosophical one, and presents the theoretical grounds of the tested hypotheses and the core findings of my study. It also clarifies how this paper addresses RQ2 and reflects on the different nuances detected under each of the tested conditions, not only validating my pre-formulated theoretical claims but also adding further insights to them. Finally, in Chapter 7, I summarise and reflect on how the papers come together to answer the overall RQ and discuss the dissertation's broader contributions, implications, and limitations as well as open trajectories for further research.

Chapter 2: Theoretical Background

The overall RQ of this dissertation – *What should the role of personal responsibility be, and how is it perceived regarding assessments of (wrongful) discrimination?* – indicates that the focal point of this endeavour is situated at the intersection between two pieces of literature: the discrimination theory and luck egalitarianism. These two literatures and their intersection point constitute the theoretical pillars of my discussion, and for that reason, they should be sufficiently clarified.

2.1 Discrimination

2.1.1 Direct Discrimination

Discrimination constitutes a frequently occurring phenomenon. We are all familiar with the usual lists of victims and perpetrators. Among those paradigmatic cases, one could easily situate the violation of non-white people's rights in the Western world as well as of women's right to self-determination and autonomy under Islamic law. But what exactly does this term mean? Definitions of discrimination abound across disciplines of philosophy and social sciences. Among those, Kasper Lippert-Rasmussen's (2013) account of direct group discrimination is probably the most prevailing. At its core, the account suggests that an agent X directly discriminates against Y in relation to Z by Φ-ing if, and only if:

1. there is a property, P, such that (X believes that) Y has P and (X believes that) Z does not have P;
2. X treats Y worse than Z by Φ-ing;
3. it is because (X believes that) Y has P and (X believes that) Z does not have P that X treats Y worse than Z by Φ-ing;
4. P is the property of being member of a certain socially salient group (to which Z does not belong); and
5. Φ-ing is a relevant type of act, etc., and there are many acts, etc. of this type, and this fact makes people with P (or some subgroup of these people) worse off relative to others, or Φ-ing is a relevant type of act, etc., and many acts, etc. of this type would make people with P worse off relative to others, or X's Φ- ing is motivated by animosity towards individuals with P or by the belief that individuals who have P are

> inferior or ought not to intermingle with others (Lippert-Rasmussen, 2013, 45-46).

Put more simply, direct group discrimination occurs when people who are perceived to be members of a socially salient group are treated less favourably than a better-treated comparator group because of their group membership.

There are two aspects of this definition worthy of further consideration, given the particular discussions that take place under each of the dissertation's papers later. First, direct group discrimination is not inherently morally wrong. In essence, the concept of discrimination understood under the cited account merely describes core features of specific actions without ascribing any kind of moral status to them. Put differently, under this definition, classifying an action or policy as discriminatory does not mean that it is wrong per se but rather that it exhibits specific characteristics. Second, the social salience of the implicated groups appears to play a crucial role so that a case of disadvantageous differential treatment is called direct group discrimination. But when is a group socially salient? Following Lippert-Rasmussen (2013, 30), 'a group is socially salient if perceived membership of it is important to the structure of social interactions across a wide range of social contexts.' For example, being (perceived as) a member of the black community in the US or a member of the LGBTQ+ community of a conservative country seems to considerably structure one's social interactions across a wide range of social contexts, i.e., their access to education, healthcare, job opportunities, their interactions with outgroup members, their right to marriage or adoption, and so on. Furthermore, social salience comes in degrees, meaning that perceived group membership can be important in more or fewer contexts (Lippert-Rasmussen, 2013, 30-31). Adding to that, we are exclusively interested in perceived and not actual membership. It is of little importance whether the individual indeed belongs to that group. All that matters is whether they are perceived by the agent of the action or the policy as members of that group. These clarifications bear considerable importance regarding the rest of my discussions, as it is questionable whether the groups targeted by responsibility-sensitive policies are socially salient (Albertsen, 2024) and, consequently, whether these policies can adhere to the above definition. I will engage with this discussion more extensively in Chapter 5.

The challenging requirement of social salience has, however, been criticised (Eidelson, 2015). Here, it is worth citing one more account of direct discrimination that does not consider this criterion. Benjamin Eidelson (2015, 17) argues that X (directly) discriminates against Y in dimension W on the basis of P if, and only if:

1. X treats Y less favourably in respect of W than X treats some actual or counterfactual other, Z, in respect of W (*Differential Treatment Condition*); and
2. a difference in how X regards Y P-wise and how X regards or would regard Z P-wise figures in the explanation of this differential treatment (*Explanatory Condition*).

Put more simply, direct discrimination occurs when Y is treated less favourably regarding a specific dimension than an actual or counterfactual other, and the difference concerning how they are perceived by the discriminator (partially) explains the occurring differential treatment. The above definition, like the previous one, adopts a non-moralised understanding of discrimination, meaning that it regards it as non-inherently wrong. Lastly, the non-inclusion of the social salience criterion probably renders this account more suitable for what follows since, as also mentioned above, it is questionable whether the groups targeted by responsibility-sensitive policies constitute socially salient ones (Albertsen, 2024). I engage properly with this discussion later in Chapter 5.

2.1.2 Wrongful Discrimination

Having determined what direct discrimination is, the next question pertains to what makes discrimination wrongful. There is an abundance of literature that attempts to elaborate on that. Some scholars attribute this wrongness to the implied disrespect that justifies the discriminatory act (Alexander, 1992; Hellman, 2018; Eidelson, 2015), while others attribute it to the imposed harm on the discriminatee after a discriminatory act has occurred (Lippert-Rasmussen, 2013; Arneson, 2018). Finally, another group of scholars focuses on subsequent freedom violations (Moreau, 2010; 2020), but since I do not examine those accounts in any of my papers, I will not discuss this perspective any further here either.

Starting with the disrespect-based viewpoint, Erin Beeghly (2017) names three main accounts in this context: the mental state (Alexander, 1992), the objective meaning or expressive (Hellman, 2018), and the deliberative failure ones (Eidelson, 2015). According to the mental state account, the wrongfulness of discrimination is detected in the pre-existing, morally objectionable mental states of the discriminator about the discriminatee's inferior moral worth that justify the occurrence of differential treatment against them (Alexander, 1992; Lippert-Rasmussen, 2013). Along similar lines, under the objective meaning/expressive account, the wrongfulness of discrimination is summarised in the socially demeaning character of those actions and policies that ascribe a status of inferiority or social unacceptability to specific individuals

(Scanlon, 2008). As Deborah Hellman suggests, disrespectful discrimination occurs whenever an action or policy entails 'an expression of a lack of respect for the equal humanity of the other' (Hellman, 2008, 36) and comes from an agent with adequate social power to ensure the significant effect of that action or policy in society (Hellman, 2018). Finally, Eidelson (2015) understands the wrongfulness of discrimination as a deliberative failure to recognise persons' due respect. He states that this deliberative failure can be perceived as either a devaluation of a person's interests absent of sufficient reasons or a generalisation that compromises persons' autonomy by evaluating them based on one's beliefs about the wider group they belong to (Eidelson, 2015).

Moving on to the harm-based understanding of wrongful discrimination, the most prevalent interpretation of that is the one provided by Lippert-Rasmussen (2013, 154-155):

> [A]n instance of discrimination is wrong, when it is, because it makes people worse off, i.e., they are worse off given the presence of discrimination than they would have been in some suitable alternative situation in which the relevant instance of discrimination had not taken place.

Put more simply, wrongful discrimination occurs when the discriminatory act imposes harm on the discriminatee that renders them worse off than before. Finally, a specific interpretation of this broader account of harmful discrimination should also be considered here, given the focus of this dissertation on the intersection of the concepts of discrimination and responsibility. More specifically, Lippert-Rasmussen (2013, 155-156) proposes a desert-prioritarian understanding of harmful discrimination. Under that, the worse off the discriminatee is, the more negative moral weight should be assigned to the imposed harm. Similarly, undeserved harm should be regarded as more morally problematic and reprehensible than deserved harm. Following that line of thought, could responsibility for one's current status of need determine people's deservingness of the imposed harm and consequently mitigate its negative moral weight? Plausible responses to this question will be discussed later in Chapters 5 and 6.

2.2 Luck Egalitarianism

The second theoretical pillar of this dissertation is luck egalitarianism (in health(care)), a responsibility-sensitive theory of distributive justice. To illustrate its core sentiments, consider the following scenario:

> Jack and John, colleagues at the same office with the same salary, are both 60 years old and equally capable of performing. Jack decides to work overtime to increase his income, while John chooses not to do so. The consequent inequality

> would intuitively be considered just because it reflects differential exercises of responsibility (Tsiakiri, 2025, 316).

Building on that sentiment, at its core, luck egalitarianism argues that 'it is bad if some people are worse off than others through no voluntary fault or choice of their own' (Parfit, 1984, p. 3, n. 5). Along those lines, luck egalitarians ascribe significant importance to the distinction between option and brute luck. The former pertains to risks and misfortune associated with informed choices for which one can be held responsible. The latter refers to risks and misfortune that simply befall individuals and lie beyond their control, being purely determined by chance. Under luck egalitarianism, merely inequalities attributed to the latter form of luck are worthy of alleviation (Dworkin, 1981; Arneson, 1989; Cohen, 1989; Roemer, 1993; Rakowski, 1993; Knight, 2013; Lippert-Rasmussen, 2016; Albertsen & Knight, 2015).

2.2.1 Luck Egalitarianism in Health(care)

To understand how these claims fare in the healthcare context, let us revisit the initial example in a reformed version. In this case, Jack and John are both 60 years old again.

> Jack chose to follow a healthy diet and exercise five times weekly throughout his adult life. Today, despite being 60 years old, he is healthy and has never needed medical care. On the contrary, although John adopted an equally healthy diet and exercised as much as Jack did, he has also been a heavy smoker for the last 20 years with relatively deteriorated health (Tsiakiri, 2025, 316).

Would this inequality be perceived as reflecting a differential exercise of responsibility, as happened earlier, and justify, on those grounds, John's deprioritisation or obligation to pay a higher out-of-pocket contribution for treatment in case both patients are simultaneously admitted to an overwhelmed hospital? In response to such questions, luck egalitarianism argues that inequalities in health expectancy resulting from individuals' own priorities are justified and, consequently, do not warrant compensation (Segall, 2010). Yet, the proponents of the theory also acknowledge the potentially determinant influence of circumstances on the formulation of one's 'personal priorities' (Segall, 2010; Albertsen, 2015).

In this context, typical responsibility-sensitive healthcare policies disadvantage certain groups of people because they present a chosen and reasonably avoidable trait that considerably contributes to their current neediness. Similarly, paradigmatic responsibility-sensitive healthcare measures include the imposition of longer waiting times before treatment provision, as well as higher premiums and insurance co-payments for receiving treatment (Davies et al., 2024; Cappelen & Norheim, 2005; Voigt, 2007; Daniels, 2011;

Cavallero, 2011; Albertsen, 2020). However, to gain a better understanding of a real-life, implemented responsibility-sensitive healthcare policy, consider the following example. More specifically, under the German statutory health insurance scheme, citizens must pay half of the cost of their dental care when they do not consistently attend their annual check-up programmes. Otherwise, if there are no gaps for over five years, their contribution could be reduced by up to 30% (Schmidt, 2007). In a similar vein, obesity is considered a justified reason to deny citizens treatment in Florida (Eyal, 2013), while several British NHS Integration Care Boards (ICBs) restrict smokers and obese people's access to elective surgery, requesting them to quit smoking for at least two months or lose some weight to be considered eligible for that (Pillutla et al., 2018).

Moving on, in the bosom of luck egalitarianism, when discussed in relation to health(care), a number of internal controversies further separates luck egalitarians into smaller groups. Those controversies pertain to the currency of egalitarian justice, the specific role ascribed to personal responsibility, and whether the distribution of health or healthcare should be the focal point. Additionally, they also refer to the questions of whether other spheres and principles should be considered when assessing one's responsibility and subsequent treatment, what the role of scarcity is in the discussion, and finally, whether the causality requirement needs to be fulfilled (Albertsen & Tsiakiri, 2023). Since this is not intended as an extensive literature review of luck egalitarianism, I will exclusively report my stance on those questions as a guiding map of my underlying assumptions, which determine the identity of the rest of my discussions.

Following the order in which the questions were presented, I remain agnostic regarding the currency of egalitarian justice across my papers. On the contrary, I clearly adopt a backward-looking understanding of responsibility. According to that, it is our past choices and actions that determine the nature and extent of our current or future claims for assistance (Albertsen & Knight, 2015). Moreover, like most luck egalitarians, I engage with a theory about the distribution of health, rather than one merely about people's access to healthcare, as I am also interested in health injustice caused by factors unrelated to one's access to healthcare (Segall, 2010; Albertsen & Knight, 2015; Albertsen, 2020). Building on that, I support an integrationist approach to luck egalitarianism, acknowledging that health-related shortfalls in advantage should be addressed with a corresponding focus on concerns in other spheres of justice that somehow relate to and affect health (Albertsen & Knight, 2015). Along similar lines, as most luck egalitarians, I adopt a pluralist perspective, believing that concerns about distributive justice may be moderated by concerns for other values, such as the satisfaction of basic needs (Segall, 2010).

For this reason, I mainly defend moderate, responsibility-sensitive healthcare policies. Finally, I advocate for responsibility-sensitive healthcare solutions merely in contexts of scarcity and when the causal requirement is fulfilled, i.e., when there is a detectable causal connection between one's choices and their corresponding level of (dis)advantage (Arneson, 2001).

2.2.2 The Critical Side of the Coin

Luck egalitarianism and its applications in healthcare have attracted extensive criticism. The difficulty of attributing causality because of the determinant effect of social (~ external to the agent) factors (Cappelen & Norheim, 2005; Feiring, 2008; Bognar & Hirose, 2014; Friesen, 2018; Andersen & Nielsen, 2016; Levy, 2019; Marmot et al., 1991; Marmot, 2005; 2015), the potentially harsh and intrusive treatment of the imprudent (Fleurbaey, 1995; Anderson, 1999; Wolff, 1998; 2010), a concern for a consequent unjustified 'moralising' of individuals and their choices and health needs (Brown, 2018), and the perpetuation of inequity and discrimination dynamics (Cavallero, 2011; Anderson, 1999; Albertsen & Tsiakiri, 2023) question their justifiability. This section will engage in more detail only with the scepticism about our ability to identify responsibility accurately (~ responsibility scepticism), the seminal critiques of harshness and intrusiveness, and the most recently raised discrimination critique as these are the ones invoked in Papers A, B, and C.

The first criticism underlines our difficulty in accurately identifying responsibility. Provided that our choices are considerably affected by the multifactorial environment within which we live, work, and interact with each other (Ahola-Launonen, 2015; 2018; Feiring, 2008; Barry, 2008; Albertsen, 2015; 2020; Friesen, 2018; Traina & Feiring, 2020; Buyx, 2008; Levy, 2019), our ability to draw a clear line between choice and circumstance appears questionable, let alone to ground any further principled discussions about responsibility on this basis. However, such criticism remains on the margins of this dissertation's argumentation as it refers to a different discussion than the one that I address. In essence, I merely engage with the principled question of whether we should consider personal responsibility when seeking distributive justice and not the practical one of identifying who is indeed responsible and for what (Tsiakiri, 2025). Building on the work of several other scholars who have only engaged with the principled discussion (Dworkin, 1981; Arneson, 1989; Cohen, 1989; Rakowski, 1993; Knight, 2013; Lippert-Rasmussen, 2016; Albertsen, 2020), I argue that we need to provide a convincing affirmative response to the former before reflecting on the latter.

Yet, the most frequently raised critique against luck egalitarianism and its healthcare applications is the harshness critique. According to this, luck egalitarianism treats those responsible for their poor condition with counter-

intuitive harshness by letting them bear the costs of their choices, regardless of how high they may be, and providing too little or even nothing for the recovery of their health (Fleurbaey, 1995; Anderson, 1999). To elaborate on this claim, proponents of this critique come up with some illustrative examples, like the following one:

> Bert has received a normal and balanced upbringing, but he has freely adopted a negligent and reckless character. In particular, he enjoys having his hair blown by the wind when he rides his motorbike on the highway, and he seldom wears a helmet even though he has one and it is compulsory to wear it. One morning he takes out his motorbike to pay a visit to his parents, and, on leaving them, spurns his mother's warnings about the helmet, saying: 'I prefer to take the risk and enjoy the wind!' But on this particular morning, Bert's careless driving causes an accident, in which he suffers serious head injuries. The hospital diagnoses a trauma which requires a costly operation Bert cannot afford because he has no health insurance. He will die if nothing is done. In this case, the equal opportunity principle would not endorse any transfer of resources to help Bert. He is fully responsible for his injury (Fleurbaey, 1995, 40).

Luck egalitarians have provided several responses to this critique (Knight, 2005; 2015; 2013; 2021; Voigt, 2007; Eyal, 2017; Stemplowska, 2017; Inoue, 2019). To only name a couple of these, consider that some argue that the invoked examples constitute extreme and rare cases if they even exist at all (Barry, 2006). Others point to pluralist solutions and supplementary prioritarian and sufficientarian values, underlining, for example, our special concern for the worse off or the need for the provision of unconditional care for those found below a particular threshold (Arneson, 2000; Segall, 2010; Voigt, 2007; Albertsen & Knight, 2015; Segall, 2010; Albertsen & Tsiakiri, 2023).

Another often-raised critique refers to the potential invasion of the private sphere that the implementation of luck egalitarianism seems to require (Wolff, 1998; 2010). Under luck egalitarian institutions and policies, a specific amount of information is necessary to identify the truly responsible. To collect that data and precisely determine the extent of their responsibility, the corresponding institutions are expected to treat potential claimants with disrespect and suspicion and even request shameful revelations from them, thereby undermining the equal respect owed to every citizen (Preda & Voigt, 2023). Here, luck egalitarians invoke similar replies to those provided against the harshness criticism, building on pluralist grounds and supplementary prioritarian and/or sufficientarian values. For instance, they argue that if prioritarian or sufficientarian reasons apply, sensitive data revelation and collection may not be necessary (Arneson, 2000; Knight, 2009; Cohen, 2004; Albertsen & Knight, 2015).

2.3 The Intersection Point – The Discrimination Critique

The two pieces of literature illustrated above eventually meet under the most recently raised critique against the luck egalitarian theory and its applications: the discrimination critique. This intersection point indicates the gap in the literature that this dissertation aims to fill. More specifically, at its core, the discrimination critique suggests that luck egalitarianism engages in wrongful discrimination against the imprudent, who are treated differentially because of their responsibility for their current health disadvantage (Albertsen, 2024; Albertsen & Tsiakiri, 2023; Tsiakiri, 2025). However, is responsibility-sensitivity in healthcare (perceived as) wrongfully discriminatory, or reversing the equation, does the presence of responsibility for the targeted feature considerably affect what counts and is perceived as a case of wrongful discrimination? This is the question my dissertation addresses, starting with the clarification of the discrimination critique in the co-authored chapter.

The critique was initially mentioned by Elizabeth Anderson in her seminal paper 'What is the point of equality?' (1999). In it, Anderson (1999) claims that luck egalitarianism appears committed to discriminating between victims of option and brute luck when it argues that those responsible for their abject condition should bear the resulting costs of their choices. More recently, other scholars have also echoed these concerns. For example, Swedish documents guiding priority setting emphasise that the 'level of self-inducement and differences in lifestyle should, as a principle, not lead to negative discrimination' (*Socialdepartementet* [Ministry of Health and Social Affairs], 1995, p. 130, cited by Björk, 2021, 41), while British scholars reflect on the potentially discriminatory underpinnings of policies that either restrict smokers and obese people's access to elective surgery (Pillutla et al., 2018) or exclude obese women from publicly funded fertility treatments, like IVF (Brown, 2019).

But to illustrate what this broad critique looks like under each of the already mentioned accounts of wrongful discrimination, consider the following. Commencing from the first account of disrespectful discrimination, the mental state one, the wrongfulness of discrimination here is situated at the problematic mental state of the discriminator about the discriminatee's inferior moral worth that justifies the former's actions (Alexander, 1992). Under this viewpoint, a claim advocating for luck egalitarianism (in healthcare) could be perceived as the outcome of a problematic mental state that implies the imprudent ones' inferior moral worth and justifies the low priority given to the satisfaction of their needs on those grounds (Albertsen & Tsiakiri, 2023; Tsiakiri, 2025).

Following the social meaning or expressive account of disrespectful discrimination, which argues that the wrongfulness of that is found in the socially demeaningness of an action or policy implemented by an agent with sufficient power to ensure its effect (Hellman, 2008; 2018), luck egalitarianism and its applications in healthcare could be criticised as socially demeaning. Through the imposition of disadvantageous differential treatment against the imprudent regarding fundamental and 'owed' benefits to every human being, as immediate access to healthcare is, it could be underlined that they express a lack of respect for the imprudent ones' humanity, contributing to their social marginalisation and consequent degradation. Moreover, since those policies are centrally implemented, the corresponding agent appears to have the required power to ensure their effect on people's lives (Albertsen & Tsiakiri, 2023).

Under the deliberative failure account, disrespectful discrimination occurs when we fail to recognise persons' due respect. This failure can be perceived as either a devaluation of one's interests without sufficient reasons or a generalisation that questions persons' autonomy by judging them based on one's beliefs for a wider group of others (Eidelson, 2015). Under the first interpretation of this account, one could argue that the policies and actions suggested by luck egalitarians constitute exceptional examples of disrespectful discrimination as they tend to ascribe inferior respect to the interests of specific groups solely due to the insufficient reason of their responsibility for being worse off. Playing devil's advocate, however, one could ask: is this reason indeed inadequate to justify such differential treatment (Albertsen & Tsiakiri, 2023)? Nevertheless, under the second interpretation of this account, luck egalitarianism and its applications (in healthcare) escape the discrimination critique since the consideration of personal responsibility could not but play the role of a proxy for respecting one's autonomy and taking into consideration all the relevant and available information (Albertsen & Tsiakiri, 2023).

Finally, according to proponents of harmful discrimination, the latter takes place when the discriminatee is made worse off because of the occurrence of the discriminatory instance than they would have been had it not occurred (Lippert-Rasmussen, 2013, 154-155). Following this claim, luck egalitarianism and its applications (in healthcare) could be perceived as harmfully discriminatory as they suggest the imprudent ones' deprivation of resources or welfare, rendering them worse off than they would have been without the particular policy (Albertsen & Tsiakiri, 2023). Yet, under a desert-prioritarian understanding of this account, we also need to factor in one's deservingness of the imposed harm. According to that, the imprudent ones' deservingness of the harm because of their responsibility for their current neediness could be perceived as a mitigating factor of the occurring wrongful discrimination's negative moral weight (Albertsen & Tsiakiri, 2023).

Chapter 3: Methodological Background

As the introduction suggested, my dissertation deals with both a normative and an empirical question. Regarding the former, I engage with the question of whether responsibility-sensitive healthcare allocation should be classified as wrongfully discriminatory and, by reversing and broadening the question, with what the role of personal responsibility for the targeted feature should be in our assessments of wrongful discrimination. Could that mitigate or even eliminate any concerns about the occurrence of wrongful discrimination or not? To respond to these questions, I employ two methodological tools of analytical philosophy: reflective equilibrium and thought experiments. Having established theoretically what the role of responsibility is and should be when we assess cases of differential treatment, especially concerning healthcare resource allocation from a discrimination-based perspective, I also examine laypeople's moral judgements regarding the occurrence of wrongful discrimination when a supposedly chosen feature is targeted. In this context, I pursue the questions of whether perceived wrongful discrimination is responsibility-sensitive and, subsequently, what the role of personal responsibility for the targeted feature is perceived to be when we assess cases of differential treatment. For that purpose, I adopt an experimental philosophical approach more aligned with the positive and exploratory programmes of experimental philosophy (X-Phi) and its bioethics (BioXPhi) branch, even though I make no explicit commitment to any of these programmes in the dissertation.

3.1 Analytical Philosophy

3.1.1 Reflective Equilibrium

The method of reflective equilibrium, popularised by Rawls in his book *A Theory of Justice* (1971), constitutes the dominant and most widely used method within moral and political philosophy (Knight, 2017; McPerson, 2015; Anderson, 2015; de Maagt, 2017). At its core, reflective equilibrium constitutes a back-and-forth process that focuses on judgments and principles, aiming to bring them into accord. Under that, equilibrium is reached when they have been mutually adjusted so that they agree in the light of relevant argument and theory (Knight, 2017; 2025). To illustrate that, consider, for example, the case under which I am committed to the principle that it is always wrong to hit another person, but I also have the judgment that it would not be wrong to

do so in cases of self-defence. To reach equilibrium, either the principle or the judgment should be revised.

Judgments constitute the starting point of this process. According to Rawls, they should exclusively include our considered judgments, i.e., those intuitions or commitments, irrespective of their generality, concerning the specific matter 'in which our moral capacities are most likely to be displayed without distortion' (Rawls, 1971, 47), meaning that we have the ability, opportunity, and desire to make the right decision (Rawls, 1971). After one's relevant considered judgments have been spelt out, one should consider every principle in every combination with every other principle to which one might plausibly conform one's judgments. Under this ideal approach, equilibrium will have been achieved when coherence between those judgments and principles has also been achieved. However, given the realistically unachievable nature of this process, we are allowed to narrow down the number of principles against which we consider our relevant judgments (Knight, 2017).

Before citing specific examples from this dissertation's particular papers, a more extensive illustrative example regarding how this method works from the reflective equilibrium literature should be presented. In his book *Justice and Justification: Reflective Equilibrium in Theory and Practice* (1996), Norman Daniels discusses the example of the standard form of criticism raised against act utilitarianism and the classic utilitarian responses to that. At its core, act utilitarianism argues for the following general moral principle: an act or policy is right if and only if it produces at least the same utility as any alternative. This principle, however, appears to justify a number of acts or policies that conflict with our ordinary moral beliefs. For example, it seems to permit the torturing, punishment, or even killing of the one or the innocent if this would avoid greater harm or produce more utility. Opponents of the theory often invoke these kinds of examples to question its soundness. Act utilitarians seriously consider those concerns and counterexamples and provide several responses. Others suggest that a careful accounting of consequences would eventually argue for those acts or policies that align with our ordinary moral judgments. According to this approach, the presented counterexamples fail to calculate utility appropriately and are consequently dismissed. Others, however, end up modifying the theory with the hope that the revised version will better match our ordinary beliefs. This exact process is the one proposed by reflective equilibrium and will be completed only when theory and moral judgments are made coherent.

Both Paper A and Paper B employ this method. To elaborate on this, Paper A begins with the researcher's considered judgment that a responsibility-sensitive healthcare allocation is justified, primarily based on a luck egalitarian viewpoint. One of the dominant criticisms raised against this perspective,

however, emphasises its disrespectful implications regarding the harsh treatment of the imprudent, the system's intrusiveness into individuals' personal sphere, and the discriminatory underpinnings of their differential treatment compared to the prudent ones. Paper A takes those critiques seriously into consideration and examines whether the initial judgment aligns with respect-based principles, like the ones put forward by the Doctrine of Double Effect (DDE) and the Kantian Formula of Humanity. The number of principles considered here was wider than the one thoroughly discussed in the paper. Yet, given the word limit and the specific focus on respect, the invoked ones are the most suitable. Overall, since the initial judgment was found to align well with the mentioned respect-based principles, this speaks in favour of the justifiability of a responsibility-sensitive healthcare allocation, at least from a respect-based point of view.

Similarly, Paper B begins with the researcher's considered judgment that responsibility-sensitive healthcare policies engage in justified differential treatment when they treat the imprudent individuals differentially. However, more and more scholars highlight those policies' wrongfully discriminatory nature. To investigate which judgment aligns better with the relevant principles and put a valid argument on the table, I test those policies' abidance with seminal definitions of direct and harmful discrimination and whether a principle regarding liability for defensive harm could have any meaningful impact on this test. I end up concluding that the assessed types of responsibility-sensitive healthcare policies conform to the invoked definitions. Nevertheless, the moderate version of those appears to escape the accusation of harmful discrimination. Building on those findings, I modify my initial judgment to argue only in favour of moderate, responsibility-sensitive healthcare policies, thereby achieving coherence between judgments and principles.

3.1.2 Thought Experiments

The second methodological tool of analytical philosophy utilised mainly in Paper A is thought experiments. As Kimberley Brownlee and Sofia Stemplowska (2017) define them,

> A thought experiment is a multi-step process that involves (1) the mental visualization of some specific scenario for the purpose of (2) answering a further, more general, and at least partly mental-state-independent question about reality.

Put more simply, thought experiments constitute devices of the imagination used to investigate our judgments about what is required of us in a particular kind of case (Brownlee & Stemplowska, 2017). Under this understanding, thought experiments can be employed to suggest what is morally required or

permissible as well as to ground and test a further hypothesis about what the correct answer is, why, and whether this can be translated into a valid argument. Following that, well-posed thought experiments should finish with an open question and never assume an answer to the question they pose. Additionally, like any other type of experiment, they should be designed in such a way that we can focus on the tested relationship in isolation from any other moderating variables that could pollute it (Brownlee & Stemplowska, 2017).

To provide an illustrative example of what counts as a thought experiment, consider the highly influential Trolley Problem introduced by Philippa Foot in her seminal paper 'The Problem of Abortion and the Doctrine of Double Effect' (2002):

> A runaway trolley is hurtling towards five people who are working on the railroad track up ahead. The driver can either continue onto the track ahead, thereby killing the five, or steer onto a second track off to the side on which only one man is working, thereby killing the one. Is it permissible to turn the trolley? (Foot, 2002, 23).

This simple thought experiment aims to identify the morally permissible act in this context, serving several purposes. For instance, some argue that it suggests it is permissible to divert the trolley since our negative duty to avoid killing the five outweighs our negative duty not to kill the one.

Narrowing down our focus on how I utilise the discussed tool, Paper A invokes the above thought experiment in a revised form when testing whether prioritising the prudent and deprioritising the imprudent can be perceived as morally permissible, with the latter exclusively constituting a side effect of our effort to bring about some good. More specifically, to avoid any consequentialist sentiments and add the aspect of responsibility to the equation, I describe a case where only one worker can be found on each track, with the one being there for reasons beyond their control and the other having chosen to be there despite being advised against doing so. Given that I end up suggesting that the prudent worker should be saved, this thought experiment is then supplemented by another one which describes a case where doctors are asked to decide to allocate a scarce resource either to a patient who is not responsible for their current neediness or to one that has considerably contributed to it. The aim of this complex thought experiment is to test whether the two cases are indeed analogous and whether what is considered morally permissible or advisable under the former is similarly considered under the latter and ground on this conclusion an argument in favour of the consideration of responsibility in the context of healthcare allocation.

3.2 Experimental Philosophy

The second methodological approach adopted in this dissertation is experimental philosophy (X-Phi). X-Phi constitutes an interdisciplinary approach that deals with questions and theoretical frameworks traditionally addressed in philosophy by employing experimental methods developed within the field of social sciences (Knobe & Nichols, 2017). Under this broad understanding, X-Phi projects gather data about laypeople's intuitions, judgments, and behaviours, which they later use to substantiate, undermine, or revise philosophical theories. For example, X-Phi has been widely used to elaborate on whether laypeople adopt a compatibilist or incompatibilist perspective regarding free will and determinism, while experimental philosophers have grounded discussions about moral responsibility on those findings.

In my project, and more specifically in Paper C, I am particularly interested in laypeople's moral judgments and intuitions regarding whether wrongful discrimination occurs when a responsibility-sensitive policy treats those responsible for their current neediness differentially. The reliability and usefulness of laypeople's (moral) judgments and intuitions for theory generation have been controversial. Yet, morality is practical, and since it affects everyone, it should be equally accessible to everyone. In other words, agents like us should have a say when theory appears to be too demanding or builds on judgments, intuitions, motivations, and/or capacities that they do not possess or are incapable of possessing (Alfano et al., 2022).

Under this general understanding of X-Phi, a diverse range of programmes takes place. Some research projects are interested in debunking more traditional philosophical methods – the appeal to intuitions – being classified as cases of the 'negative programme'. Others aim to make further progress and support claims and questions already addressed within analytical philosophy and are consequently classified as cases of the 'positive programme'. Finally, others are directly focused on exploring people's thoughts and feelings, being perceived as cases of the 'exploratory programme'. Yet, even though this metaphilosophical distinction seems neat and clear, most of the time, concrete X-Phi research projects end up being relevant to more than one, if not all, of those programmes (Knobe & Nichols, 2017). Although I make no explicit commitments to any of these programmes, my project is a typical case of the latter kind of research projects. In what follows, I unpack each of the named programmes and indicate how my project speaks to each one of them.

Starting with the negative programme, it aims to provide evidence that there is something flawed or unreliable in using people's intuitions for addressing substantive philosophical questions. As its proponents suggest, we should not be relying uncritically on people's intuitions as they are often found

to be influenced by demographic and cultural factors or order effects (Weinberg et al., 2001; Swain et al., 2008; Cameron et al., 2013; Buckwalter & Stich, 2014). In fact, Paper C reports the findings of a cross-country experiment examining cross-cultural and cross-domain differences in people's responses. However, contrary to what the negative programme argues for, Paper C's relevant discussions aim to make progress on the relevant questions and philosophical perspectives. In essence, they imply that one size does not fit all cases and that we should also take into consideration, to a reasonable extent, those kinds of differences when generating binding normative claims that seem to apply to everyone, regardless of their cultural, demographic, or other traits.

The positive programme sees potential in people's intuitions regarding progress on relevant philosophical issues. By drawing on theories about the topic under study, research projects under the positive programme deal with specific hypotheses concerning the underlying cognitive processes that generate intuitions in a particular domain. These hypotheses are perceived as being able to help us assess which of the domain's intuitions are trustworthy to build further philosophical argumentation on and which should be ignored or dismissed (Gerken, 2017; Leslie, 2013; Nagel, 2010; Greene, 2008). The experimental philosophical part of this dissertation aligns well with this programme. Specifically, there is a well-documented controversy between those who suggest that personal responsibility for a trait or condition is a morally relevant property when assessing cases of distribution or differential treatment on these grounds and their opponents. The reported experiment elaborates on which standpoint is adopted and considered justified by laypeople. Adding to that, as also underlined above, the investigation of any cross-cultural and cross-domain differences and the corresponding findings add interesting nuances to the literature. In essence, they indicate that even though participants of both countries, when exposed to vignettes of both domains, confirmed the same claim, i.e., that personal responsibility is a morally relevant property, we should always be mindful of the particular characteristics of the studied populations, which seem to influence their responses statistically significantly.

Finally, the exploratory programme includes research projects that aim to make progress on questions directly focused on people's thoughts and feelings as such, i.e., their underlying cognitive processes, as opposed to unpacking their thoughts, feelings, and intuitions about a different topic (Knobe & Nichols, 2017). Aligning only partially with such a programme, Paper C and the reported experiment are also interested in directly exploring and mapping patterns of variation and convergence in people's moral judgments based on factors like their country of origin, the salience of the discussed topic, the specific understanding of the dependent variable, the different operationalisations of the independent variable – either as a dichotomous or a continuous

one – and the consideration of future and/or current personal concerns. However, unlike projects that fit fully within the exploratory programme, this work ultimately uses those empirical findings to inform a normative debate about responsibility and discrimination rather than pursuing cognitive mapping as an end in itself.

Before elaborating on the specific experimental tool used in Paper C, I would also like to emphasise the project's partial alignment with a particular branch of X-Phi, namely experimental philosophical bioethics (BioXPhi). The recently established branch of BioXPhi employs the tools of cognitive science, moral psychology, and experimental philosophy to examine topics traditionally associated with bioethics, seeking to contribute to substantive normative debates in this context. It aims to (a) facilitate studies that engage with a broader range of stakeholder intuitions and judgments than merely those of philosophers and bioethicists; (b) explore how those judgments develop in more ecologically valid contexts; and (c) provide a richer understanding of the cognitive processes and impactful factors behind people's judgments by mapping, for example, the variation of their judgments as an outcome of carefully controlled conditions (Earp et al., 2021; Lewis et al., 2023).

To get an idea of how Paper C partially complies with the above aims, consider that it (a) engages with unpacking laypeople's intuitions and judgments about the responsibilisation of the healthcare system; (b) explores those judgments and how they develop in a more ecologically valid context formed by realistically described cases of potential real-world scarce healthcare resource allocation; and (c) provides a richer understanding of the role that personal responsibility for one's neediness plays in laypeople's assessment of cases of differential treatment on these grounds and whether they perceive them as morally justified, at least from the discrimination point of view. It then uses those findings to contribute to the relevant substantive normative debates about the justifiability of factoring in one's responsibility for one's current neediness when the allocation of scarce healthcare resources is considered.

Finally, narrowing our focus to the specific experimental tool employed by Paper C, it utilised a vignette survey experiment, manipulating one variable – personal responsibility – to measure its impact on perceived wrongful discrimination. By carefully describing a particular situation of a patient or an unemployed person in need of a scarce resource who is denied access to that because of a trait/condition for which they can or cannot be held responsible, I compared participants' responses to pairs of vignettes that differed on one specific detail, namely the extent of responsibility attributed to the vignette subject. In this context, since participants were randomly assigned to two vignettes – one related to healthcare and one to welfare provision – in random

order, any differences between their response distributions should be attributable to the experimental manipulation.

Intermezzo

If
Αν

If you can keep your head when all about you
Αν να κρατάς καλά μπορείς το λογικό σου, όταν τριγύρω σου όλοι

Are losing theirs and blaming it on you,
τάχουν χαμένα και σ' εσέ της ταραχής των ρίχνουν την αιτία.

If you can trust yourself when all men doubt you,
Αν να εμπιστεύεσαι μπορείς τον ίδιο τον εαυτό σου, όταν ο κόσμος δεν σε πιστεύει

But make allowance for their doubting too;
κι αν μπορείς να του σχωρνάς αυτή τη δυσπιστία.

If you can wait and not be tired by waiting,
Να περιμένεις αν μπορείς δίχως να χάνεις την υπομονή σου.

Or being lied about, don't deal in lies,
Κι αν άλλοι σε συκοφαντούν, να μην καταδεχθείς ποτέ το ψέμα,

Or being hated, don't give way to hating,
κι αν σε μισούν, εσύ ποτέ σε μίσος ταπεινό να μην ξεπέσεις,

And yet don't look too good, nor talk too wise:
μα να μην κάνεις τον καλό ή τον πολύ σοφό στα λόγια.

If you can dream — and not make dreams your master;
Αν να ονειρεύεσαι μπορείς, και να μην είσαι δούλος των ονείρων,

If you can think — and not make thoughts your aim;
αν να στοχάζεσαι μπορείς, δίχως να γίνει ο στοχασμός σκοπός σου,

If you can meet with Triumph and Disaster
αν ν' αντικρίζεις σου βαστά το θρίαμβο και τη συμφορά παρόμοια

And treat those two impostors just the same;
κι όμοια να φέρνεσαι σ' αυτούς τους δυο τυραννικούς απατεώνες,

If you can bear to hear the truth you've spoken
αν σου βαστά η ψυχή ν' ακούς όποιαν αλήθεια εσύ είχες ειπωμένη,

Twisted by knaves to make a trap for fools,
παραλλαγμένη απ' τους κακούς, για νάναι για τους άμυαλους παγίδα,

Or watch the things you gave your life to, broken,
ή συντριμμένα να θωρείς όσα σου έχουν ρουφήξει τη ζωή σου

And stoop and build 'em up with worn-out tools:
και πάλι να ξαναρχινάς να χτίζεις μ' εργαλεία πούναι φθαρμένα.

If you can make one heap of all your winnings
Αν όσα απόχτησες μπορείς σ' ένα σωρό μαζί να τα μαζέψεις

And risk it on one turn of pitch-and-toss,
και δίχως φόβο, μονομιάς κορόνα ή γράμματα όλα να τα παίξεις

And lose, and start again at your beginnings
και να τα χάσεις και απ' αρχής, ατράνταχτος να ξεκινήσεις πάλι

And never breathe a word about your loss;
και να μη βγάλεις και μιλιά ποτέ γι' αυτόν τον ξαφνικό χαμό σου.

If you can force your heart and nerve and sinew
Αν νεύρα και καρδιά μπορείς και σπλάχνα και μυαλό και όλα να τα σφίξεις

To serve your turn long after they are gone,
να σε δουλέψουν ξαναρχής, κι ας είναι από πολύ καιρό σωσμένα

And so hold on when there is nothing in you
και να κρατιέσαι πάντα ορθός, όταν δε σούχει τίποτε απομείνει

Except the Will which says to them: 'Hold on!'
παρά μονάχα η θέληση, κράζοντας σ' όλα αυτά: «ΒΑΣΤΑΤΕ».

If you can talk with crowds and keep your virtue,
Αν με τα πλήθη να μιλάς μπορείς και να κρατάς την αρετή σου,

Or walk with Kings — nor lose the common touch,
με βασιλιάδες να γυρνάς δίχως απ' τους μικρούς να ξεμακρύνεις.

If neither foes nor loving friends can hurt you,
Αν μήτε φίλοι, μήτ' εχθροί μπορούνε πια ποτέ να σε πειράξουν,

If all men count with you, but none too much;
όλο τον κόσμο αν αγαπάς, μα και ποτέ πάρα πολύ κανένα.

If you can fill the unforgiving minute
Αν του θυμού σου τις στιγμές που φαίνεται αδυσώπητη η ψυχή σου,

With sixty seconds' worth of distance run,
μπορείς ν' αφήσεις να διαβούν την πρώτη ξαναβρίσκοντας γαλήνη,

Yours is the Earth and everything that's in it,
δική σου θάναι τότε η Γη, μ' όσα και μ' ότι απάνω της κι αν έχει

And — which is more — you'll be a Man, my son!
και κάτι ακόμα πιο πολύ: Άνδρας αληθινός θάσαι παιδί μου.

Rudyard Kipling, 1910
Μετάφραση Ν. Καρβούνης

Chapter 4: Why a Responsibility-Sensitive Healthcare System Is Not Disrespectful

As mentioned in Chapter 2, luck egalitarianism argues that it is bad if some people are worse off than others because of reasons that lie beyond their control, implying that only those inequalities are worthy of alleviation (Dworkin, 1981; Arneson, 1989; Cohen, 1989; Roemer, 1993; Rakowski, 1993; Knight, 2013; Lippert-Rasmussen, 2016; Albertsen & Knight, 2015). When applying those abstract claims to the healthcare context, proponents of the theory suggest that inequalities in health expectancy due to personal priorities are justified and might not be compensated (Segall, 2010), acknowledging, however, the determinant role that external factors could have played in the formulation of those priorities (Segall, 2010; Albertsen, 2015). Yet both the theory and its applications, particularly in the healthcare context, have been extensively criticised. Among others, the great majority of critics focuses on a concern for respect violations that could be expressed through the probable harsh treatment of the imprudent (Fleurbaey, 1995; Anderson, 1999); the system's intrusiveness to people's private spheres, sometimes requesting shameful revelations from them (Wolff, 1998; 2010; Preda & Voigt, 2023); and the perpetuation and even exacerbation of discrimination dynamics (Anderson, 1999; Björk, 2021; Kennet, 2024). By adopting a reflective equilibrium approach supplemented by thought experiments, Paper A defends luck egalitarianism and a responsibility-sensitive healthcare system against this group of objections, invoking arguments from the deontological tradition that highlight how respect is promoted instead of undermined in this context (Tsiakiri, 2025).

In what follows, I first engage with the core arguments of Paper A developed in defence of luck egalitarianism and its healthcare applications, simultaneously providing illustrative examples. The first argument discussed in there builds on the principles articulated by the DDE, while the second one builds on the Kantian Formula of Humanity and the concept of perfect duties. I then turn my focus to elaborating from a respect-based point of view on how Paper A and the corresponding discussions address RQ1, which asks the following: To what extent should responsibility-sensitive healthcare resource allocation be considered (wrongfully) discriminatory? Finally, I reflect on further considerations that result from those discussions, such as whether a utilitarian argument could also support the same core claims put forward by the deontological arguments.

4.1 Responsibility-Sensitivity in Healthcare Through the Lens of the Doctrine of Double Effect

At its core, the DDE argues that it is morally permissible to cause some unintended but foreseeable harm while trying to bring about some good, given that some additional conditions are equally satisfied (Jackson, 2011; McIntyre, 2019). In other words, it suggests that the resulting harm of our effort to bring about some good when understood merely as the side effect of the morally acceptable and even preferable action is morally permissible, provided that:

a. proportionality is satisfied, i.e., the positive moral value of the intended action surpasses the negative moral value of its side effect (Jackson, 2011; McIntyre, 2019);
b. harm minimisation is equally satisfied, i.e., the caused harm is minimised as much as possible (Walzer, 1977);
c. the intended action is difficult to prevent;
d. the intended action is morally acceptable, i.e., an action that in its very essence is good or at least indifferent; and
e. the foreseeable but unintended harm is merely a side effect and not the means to another justified end (Badger, 2011; Jackson, 2011; McIntyre, 2019; Woolard & Howard-Snyder, 2022).

The DDE is often illustrated via the Trolley Problem thought experiment, where, as explained in § 3.1.2, the driver of a trolley needs to choose between letting the trolley continue its undisturbed course, killing five people, or diverting it to another track where only one person is found. If killing the one is perceived merely as a side effect of a morally good action – saving the five – and also fulfils the conditions of proportionality, harm minimisation, and difficult prevention, then diverting the trolley and killing the one are depicted as morally permissible.

Along similar lines but also aiming to present an argument free of any consequentialist sentiments and sensitive to responsibility, Paper A revised the initial trolley scenario and proposed a corresponding one-to-one case. This was then further revised and applied to the healthcare context. Under the healthcare version, some doctors need to decide how to allocate one cornea transplant between two patients: a prudent one, who has taken good care of their eyes throughout their whole life but recently suffered a bacterial infection, and an imprudent one, who has been an obsessive model maker in their free time since they can remember, systematically using power tools without wearing safety glasses, while they have been also overusing the same pair of contact lenses (Tsiakiri, 2025, 319). Approaching this case in a manner analogous to the way the classic Trolley Problem is approached under the DDE,

Paper A reflects on whether prioritising the prudent could be seen as satisfying the core claim and conditions of the DDE and, consequently, be regarded as the morally permissible thing to do. Prioritising the prudent is suggested to be morally permissible since the deprioritisation of the imprudent is merely a side effect of the occurring morally permissible action and not a means to another justified end, the choice between the two patients is challenging to prevent, and proportionality is even found to be satisfied given that the healthier lifestyle is promoted in the long term. Under this conclusion, everyone is regarded as worthy of treatment. However, as a side effect of that consideration, in pressing conditions, it is morally permissible for the imprudent to wait longer before being treated or pay higher out-of-pocket contributions for receiving treatment.

4.2 Responsibility-Sensitivity in Healthcare Through the Lens of a Duty for Respect

The second argument developed in Paper A builds on the core of Kantian deontology, specifically Kant's Formula of Humanity and his concept of perfect duties. According to the Formula of Humanity, we should always 'act in such a way that we treat humanity, whether in our own person or the person of any other, never simply as a means but always at the same time as an end' (Kant, 1998, p. 4:429). In other words, human beings are rational beings and thus, ends in themselves that should always be treated with dignity (Kant, 1998; Dillon, 2021). Under this claim, Kant also proposes and interprets the concept of perfect duties to oneself and others, which, in simple terms, are prescriptions of certain kinds of actions from which no exception is allowed, for example due to an irrational tendency to act differently or exhibit a different type of behaviour (Kant, 1998). Building on those concepts, what the current argument aims to suggest is that we do have a perfect duty to ourselves and others to preserve our health and that we can consequently be held responsible for failing to do so.

To elaborate on how those duties work, Kant proposes a few illustrative examples. Similarly, I present some analogous cases to suggest whether it can be argued that we have a duty to ourselves and others to maintain our health. For instance, when it comes to duties to others, Kant reflects on the hypothetical scenario of a person who borrows money and promises to pay it back but does not actually intend to do so. Following Kant, such behaviour would question the very essence of the concept of promise as it would treat humanity in others' persons merely as a means, implying our perfect duty to others to keep our promises (Kant, 1998). Accordingly, one's reckless health-related behaviour could question the healthcare system's effectiveness and ability to

promote health under conditions of scarcity in the long or short term, threatening others' fair share in healthcare and life. This behaviour and the subsequent possibility would treat others as mere means, undermining their ends and rights, and suggest that our perfect duty to others is to remain healthy and thus avoid burdening the healthcare system (Tsiakiri, 2025).

Overall, building on these scenarios and the claims articulated under them, Paper A puts forward the following standardised argument here:

a. We have a perfect (~ binding) duty to ourselves and others to preserve our health.
b. A self-inflicted unhealthy lifestyle may be considered an instance of failing the duties mentioned in (a).
c. When we fail to abide by the duties suggested under (a), we treat some (ourselves or others) as a mere means and disrespect them.
d. We have respect-based reasons to seek to moderate, prevent, or eliminate instances of such failings.
e. A responsibility-sensitive healthcare system could be a mechanism that incentivises against such failings by treating people as means and ends in themselves and, consequently, by eliminating disrespect against themselves and others (Tsiakiri, 2025, 322).

Yet, before discussing explicitly how Paper A addressed RQ1, we should reflect on two further points about this argument. First, a critical reader could raise the concern that it ends up being overdemanding, leaving little space for genuine moral agency (Axelsen & Nielsen, 2020). Following that line of thought, under the above argument, every cigarette smoked, fatty meal eaten, or round of drinks consumed should amount to a failure of one's duty to themselves and/or others to safeguard their health. However, in contrast to that, I argue for a much less demanding claim suggesting that to fail one's duty to oneself and/or others, we need to repeatedly engage in actions for which there is empirical evidence that they could probably, over time, and eventually lead to a significant deterioration of our health, risking to exceed our fair share of healthcare at others' expense. Thus, although each isolated incident of an unhealthy lifestyle might contribute to the eventual outcome, it is the causally relevant aggregated impact of the adopted habits that leads us to fail our duty.

Another critical reader could also question the soundness of the implied step from proving our duties to ourselves and others to preserve our health to grounding on that an argument in favour of a system that holds us accountable for failing to do so. Yet, as a counterargument to this concern, consider Ronald Dworkin's positions on the relationship between liberty and equality in a just society and the role of the community in securing that. Following Dworkin, '[l]iberty is not the freedom to do whatever one wants no matter what, but to

do whatever one wants that respects the true rights of others' (Dworkin, 2000, 237). Along those lines, a community 'must outlaw theft, for example, to protect people's rights to security of property' and, overall, any other conduct that could violate others' true rights (Dworkin, 2000, 282). Similarly, Victor Tadros (2011) argues that it should be justified for the state to impose coercive measures to ensure the effective fulfilment of our relevant moral duties (to others) when something like that is considered necessary. Building on that, a community seems justified in preventing our potential failure to conform to our duties to preserve our health and the subsequent disrespect to others' entitlements to their true rights by adopting coercive measures, such as a responsibility-sensitive healthcare system. On those exact grounds, a step from duties to policies appears justifiable.

4.3 Addressing RQ1

Making it all come together, Paper A provides a clear response not only to RQ1, which asks: To what extent should responsibility-sensitive healthcare resource allocation be considered (wrongfully) discriminatory?, but also to the whole respect-based family of objections raised against luck egalitarianism and its healthcare applications, i.e., the harshness, intrusiveness, and discrimination ones. More specifically, building on the above arguments, Paper A advocates for a qualified 'yes' regarding the justifiability of a responsibility-sensitive healthcare system, at least from a respect-based perspective. In essence, no disrespectful mental state regarding people's moral worth appears to justify responsibility-sensitivity. At the same time, no one is treated as socially unacceptable, with their interests receiving less respect than others. Adding to that, intrusiveness to people's private spheres appears equally justified as a form of respect and not as a questioning of their autonomous volition. Therefore, the DDE-based argument and the duties of (self-)respect from which we cannot escape depict the consideration of personal responsibility in the healthcare sphere as a depository of dignity, and not as a form of disrespectful treatment or punishment as its critics suggest. Finally, to address RQ1 directly, based on the above claims, even though luck egalitarianism and its healthcare applications indeed engage in differential treatment between the prudent and the imprudent, this is of the justified kind and not of the disrespectful one.

4.4 Further Reflections

As an endnote to Chapter 4, we should reflect on one further point. More specifically, in Paper A, I introduced a novel deontological argument in favour of responsibility-sensitivity. Yet, there is still room for further supportive argumentation. For example, someone could build on utilitarian grounds. To

briefly elaborate on that, utilitarians assess the soundness of choices and actions and the agent's responsibility for their actual and foreseen consequences based on the proportionality of the produced happiness and the averted pain (Bentham, 1961). Following this line of thought, one's failure to adopt the path of action that is expected to produce the most good or avert the most harm would render them responsible for the new but degraded state of affairs (Savulescu et al., 2020). Under this perspective, individuals with self-inflicted poor health, able to predict the deterioration of their health and the potential overburdening of the medical system, would be held responsible for their reckless choices and actions. In essence, the subsequent and foreseen harm of their choices, proportionally greater than any short-term happiness they might have experienced, would underline those choices and actions' blameworthiness and imply solid grounds for the justifiability of considering responsibility as an allocation criterion.

Moreover, one could also bring forward an additional utilitarian argument by invoking John Stuart Mill's 'harm principle'. According to the latter, 'the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent (non-consensual) harm to others' (Mill, 1977, 223-224; Mill, 1969). Since health-related reckless behaviour can potentially harm others by, for instance, exploiting their fair shares of healthcare, one could argue that power or constraints can be rightfully imposed on the imprudent against their will so that non-consensual harm to the rest of society is prevented.

Chapter 5: Responsibility-Sensitive Healthcare Policies: (Harmfully) Discriminatory or Not?

In Paper A, it was established in the abstract that considering personal responsibility regarding healthcare resource allocation promotes rather than undermines (self-)respect, contrary to what the theory's critics claim. As also mentioned in § 2.2.2 and Chapter 4, the respect-based family of objections offers different interpretations of the occurring disrespect, focusing on the harsh treatment of the imprudent, the system's intrusiveness into people's private spheres, or the formulation and/or perpetuation of discriminatory dynamics. Since only the first two understandings of that objection have been extensively discussed and several luck egalitarians have attempted to counter them, I focus on the latter and less well-addressed one, namely, the discrimination critique.

In contrast to Paper A, Paper B develops in a more applied way, examining whether specific applications of the responsibility-sensitive perspective, i.e., particular types of responsibility-sensitive healthcare policies, abide by seminal definitions of direct and harmful discrimination[1] or whether any mitigating factors outweigh concerns for wrongful discrimination, rendering them justified, at least from the discrimination-based point of view.

Paper B deals with two types of policies: a) the so-called backward-looking[2] responsibility-sensitive healthcare policies (RSHPs), and b) a specification of the original concept structured around the idea of golden opportunities (GOs). RSHPs constitute those policies that disadvantage certain groups of

1. Paper A adopted a respect-based understanding of the discrimination critique. For the sake of complementarity, Paper B discusses specific types of responsibility-sensitive healthcare policies under the harm-based understanding of wrongful discrimination, currently the other dominant account of wrongful discrimination. This allows for a broader defence of the theory and its moderate applications across the full spectrum of philosophical debates on what makes discrimination wrongful.

2. In the philosophical literature, two contrasting models for approaching responsibility can be found: the backward-looking and the forward-looking models. The former and most prevalent one grounds assessments about an individual's responsibility on their past contributions to the current condition. The latter holds individuals responsible for their intended future outcomes (Bærøe & Cappelen, 2015; Feiring, 2008; Nielsen & Andersen, 2014). Paper B and the dissertation as a whole adopt a backward-looking understanding of approaching responsibility.

people because they present certain chosen and reasonably avoidable traits that significantly contribute to their current neediness and for which they could be held responsible. A real-world example of an already implemented RSHP can be found under the German statutory health insurance scheme. According to this, citizens are asked to pay half of the cost of their dental care if they do not attend their annual check-up programmes consistently. Otherwise, if there are no gaps for over five years, their contribution could be reduced by as much as 30% (Schmidt, 2007).

According to proponents of GOs (Savulescu, 2018; De Marco et al., 2021; Davies & Savulescu, 2019), they work as follows. When people's critical condition has been assessed, they should be provided with a GO, i.e., an offer of an alternative lifestyle or behaviour that:

a. has either the same health and non-health-related value but fewer risks, or greater objective value but the same risks as the existing lifestyle, and
b. is realistically adoptable (Savulescu, 2018, 60).

The proponents of this specification acknowledge the validity of the concerns usually raised against luck egalitarianism concerning the difficult attribution of causality and identification of the truly responsible. For this reason, they create an isolated moment in time when external conditions are supposed to be controlled, allowing responsibility to be assessed with adequate accuracy. In this context, even though responsibility is still the primary allocation criterion, it is responsibility for rejecting a GO and not for one's past behaviour that matters (Savulescu, 2018; De Marco et al., 2021; Davies & Savulescu, 2019). To illustrate how that type of policy works, consider the following example (Savulescu, 2018, 60-61). Jim has chronic obstructive airways disease and will probably need a lung transplant in the relatively near future. Both his friends and family and Jim himself are heavy smokers, and he has found it impossible to quit smoking with the current programmes. Realising his condition, his doctors offer him a GO: switch to smoking e-cigarettes and receive behavioural support in parallel. E-cigarettes seem to provide users a similar level of satisfaction to conventional cigarettes but fewer risks because they contain nicotine, the addictive substance in conventional cigarettes, but not tobacco, the leading cause of lung cancer (Cancer Research UK, 2023; McNeill et al., 2022). Additionally, Jim could save some money as e-cigarettes would be subsidised by the state, making the opportunity even more attractive. If Jim rejects the given offer, we should be justified in considering and holding him accountable for the further deterioration of his already poor health condition and, for instance, giving him lower priority or imposing financial burdens on him for receiving treatment.

Taking this all into consideration, Paper B directly addresses the question of whether RSHPs and GOs are directly and/or harmfully discriminatory by systematically testing whether they conform to seminal definitions of direct and harmful discrimination. A response to this question is considered critical since the likely confirmation of the accusation would further question luck egalitarianism's justifiability and demand further argumentation in support of that. Therefore, in what follows, I put RSHPs and GOs to the test of direct and harmful discrimination and examine a possible mitigating factor that could argue against the raised discrimination objection. I then provide a direct response to RQ1 and engage with further reflections about, for example, the different understandings of responsibility and potential implications of those for my argumentation, and the limited applicability of GOs.

5.1 RSHPs: Directly and/or Harmfully Discriminatory or Not?

The first sub-question addressed in Paper B asks the following: are RSHPs cases of direct discrimination? There are various definitions of direct discrimination, but the ones invoked in the paper are non-moralised, meaning that they do not perceive discrimination as a morally objectionable concept per se. More specifically, as also mentioned in Chapter 2, according to Eidelson (2015, 17), X directly discriminates against Y if and only if they treat Y less favourably than they treat an actual or counterfactual Z, and a difference in how X regards Y and Z concerning a particular feature figures in the explanation of this differential treatment. When RSHPs are assessed through those lenses, it could be suggested that they treat the imprudent less favourably than the prudent, and their perception of the imprudent as responsible for their current neediness figures in the explanation of this differential treatment. Thus, under this definition, RSHPs indeed constitute cases of direct discrimination.

But is this also the case under more challenging definitions, like the one introduced by Lippert-Rasmussen (2013, 45-46)? In brief, under this account, direct group discrimination is the disadvantageous differential treatment of the other who belongs to a socially salient group that has or is believed to have a particular property P. As also highlighted above, RSHPs engage in differential treatment between the prudent and the imprudent to the detriment of the latter. Thus, the questions that do remain unanswered here are the following: a) what is the relevant property P, and b) are any of the groups targeted by RSHPs socially salient? Regarding question a), different responses could be provided when addressed in ideal conditions and when in more applied conditions. Under ideal conditions, it could be one's 'voluntarily chosen health-

related imprudence', while under more applied conditions, one's 'allegedly self-inflicted poor health status'.

When it comes to question b), Lippert-Rasmussen (2013, 30) defines social salience as follows: 'A group is socially salient if perceived membership of it is important to the structure of social interactions across a wide range of social contexts'. Given that RSHPs target multiple groups, no response about their social salience can fit all cases, and this complexity explains why other scholars doubt whether they can realistically meet this condition and therefore amount to cases of direct group discrimination (Albertsen, 2024). Since it is impossible to examine all the targeted groups, I argue that proving the existence of at least one socially salient group among those targeted by RSHPs is sufficient to demonstrate that they can also adhere to the above definition. Therefore, consider the case of smoking. Being a smoker already appears to have a significant impact on people's interactions within the school environment. There, smoking is strictly prohibited, and students are often expelled when they do not conform to the rules. Additionally, it can determine one's access to healthcare (Pillutla et al., 2018) as well as to employment (Sulzberger, 2011). But its impact may be even broader as smoking can often be the reason why a person is rejected as a partner or friend, frequently being associated with degrading beliefs. Based on the above, being a smoker means being perceived as a member of a socially salient group. Consequently, an RSHP that targets a truly socially salient group, like smokers, and potentially all of them, can comply with Lippert-Rasmussen's definition (2013, 45-46), constituting cases of direct group discrimination.

The second sub-question addressed in Paper B asks the following: are RSHPs cases of harmful discrimination? There are different accounts of harm-based discrimination. However, the dominant view states that harmful discrimination occurs when people are made worse off because of an instance of discrimination than they would have been in an alternative situation where the relevant instance of discrimination had not occurred (Lippert-Rasmussen, 2013, 154-155). Initially, RSHPs appear to abide by this definition as the impudent individuals targeted by the implemented RSHP are indeed made worse off than they would have been had it not been implemented because of the occurring differential treatment. Put simply, if it were not for the occurrence of discrimination, they could have continued behaving recklessly, enjoying equal treatment with the prudent ones.

But is this the whole story, or are there certain factors that mitigate the negative moral weight of the differential treatment that occurs? Since both RSHPs and the discussion around liability to defensive harm are motivated by the imposition of some avoidable harm or cost on an innocent other and the potential implications that this should have for the 'aggressor', I invoke the

responsibility account of the 'liability to defensive harm' concept to answer the above question. According to Jeff McMahan (1994; 2005, 386), the concept generally holds that people may lose their moral immunity to intentional harm due to their actions or behaviour, and thus become liable, to wit, morally vulnerable to defensive harm.

However, let me employ the responsibility-based understanding of those overarching claims. Following proponents of this account, the latter engages in this discussion via a particular conception of distributive justice, under which 'fairness requires individuals to bear the costs of their own risk-imposing activities' (Frowe & Parry, 2022, 9). According to this viewpoint, a person is rendered liable to defensive harm when they bear (a) moral responsibility for (b) (a threat of) an objectively unjustified harm to others, namely, responsibility for a harm that would not otherwise have occurred and now must be borne by another individual. Before examining whether RSHPs' targets adhere to these conditions and are, as a result, liable to defensive harm, justifying the differential treatment that occurs to their detriment, the invoked understanding of moral responsibility should be clarified. Specifically, I adopt the account introduced by John Fischer and Mark Ravizza (1998). According to them, moral responsibility has two necessary requirements: an epistemic and a control requirement. To bear moral responsibility for an action or behaviour, an agent first needs to be able to foresee the (likely) consequences of her actions, understanding how they could influence the world and herself (~ the epistemic requirement), and second have enough control over them by being able to act differently (~ the control requirement) (Fischer & Ravizza, 1998).

Thus, the crucial question posed here is the following: Are the imprudent individuals morally responsible for imposing an objectively unjustified harm on others? Starting from moral responsibility and its epistemic requirement, it could be argued that the contemporary average individual is exposed to sufficient information regarding the potentially devastating effect on her health status of smoking, overeating, excessive alcohol consumption, etc. As a result, she appears to be able to foresee the likely consequences of her actions, adhering to the epistemic requirement. However, when we turn to the control requirement, it seems challenging, if not impossible, to determine the extent of control exercised by the agent, given the significant effect of social determinants on people's health-related choices and habits. This realisation questions the possibility of fulfilling this requirement. But does the truly imprudent indeed impose an objectively unjustified harm on others? Since she behaves recklessly and risks externalising reasonably avoidable burdens onto individuals who have neither consented nor became liable for them (Davies & Savulescu, 2019), I would be inclined to suggest that this condition is indeed

fulfilled. Therefore, based on the above, harmful discrimination does occur under RSHPs – an inference that questions the justifiability of their implementation.

5.2 GOs: Directly and/or Harmfully Discriminatory or Not?

Do the above inferences, however, also generalise to GOs although their proponents argued that they fare better against the usually raised concerns of RSHPs? Building on that, the third sub-question addressed in Paper B asks the following: are GOs also cases of direct discrimination? Following the same structure as earlier, we begin by examining whether GOs adhere to Eidelson's account of direct discrimination (2015, 17). As implied by their definition, GOs treat those who rejected the offered opportunity less favourably and factor this into the explanation of the occurring differential treatment. Consequently, they do abide by this definition and, as a result, constitute cases of direct discrimination.

But do they also comply with Lippert-Rasmussen's more demanding account (2013, 45-46)? Since the occurrence of differential treatment has already been identified under Eidelson's account, the two questions worthy of consideration again here are the following: a) what is the relevant property P, and b) are any of the targeted groups from GOs socially salient? Regarding question a), it is pretty straightforward that the property P here, which distinguishes people into two distinct groups, equals the rejection of the provided offer. In contrast to what happened earlier, however, the holders of this property do not seem to belong to a socially salient group. Essentially, even though rejecting a GO would determine one's access to healthcare and potentially impact one's job opportunities, this membership would remain essentially undetectable and would not significantly influence our social interactions across a wide range of social contexts. On these grounds, GOs escape the discrimination critique under Lippert-Rasmussen's account, something that constitutes a promising finding regarding the justifiability of their implementation compared to RSHPs.

Finally, the fourth sub-question addressed in Paper B asks the following: Are GOs also cases of harmful discrimination? Like before, they seem to qualify as such at first glance since they make those who rejected the provided GO worse off than they would have been had those policies not been implemented. But could the negative moral weight of the occurring differential treatment be mitigated? Again, one promising way to suggest that this is the case would be to prove the targets of GOs' liability to defensive harm. Thus, the crucial question posed here is whether GOs' targets are morally responsible for imposing

an objectively unjustified harm on others. Starting from the end this time, provided that we discuss the same type of harm again, i.e., the potential externalisation of reasonably avoidable costs, it seems reasonable to suggest that the second condition of liability to defensive harm is fulfilled. But are GOs' targets also morally responsible for that harm?

Regarding the epistemic condition of moral responsibility, it should be stated that the contemporary average individual is expected to satisfy this condition as she appears to be exposed to the required information, allowing her to foresee the likely consequences of her actions and behaviours adequately. Additionally, individuals who are provided with a GO will also be informed about the implications of their decision to reject the given offer. Regarding the control condition of moral responsibility, I am inclined to argue that it is also fulfilled in this context. To illustrate why this is the case, consider that by definition GOs are realistically adoptable alternative lifestyles, and their choosability should be enhanced in any way possible by the state. Under such an understanding, rejecting a GO constitutes an exercise of one's control since she could have acted differently but decided to behave in this specific way.

All in all, unlike RSHPs, GOs' targets appear to be liable to defensive harm, something that justifies the disadvantageous differential treatment they face under such policies. Any proportional harm they incur is therefore traceable to their own choices and behaviour that preceded the policy. Thus, while GOs do involve harmful discrimination, this is of a justified form due to the agent's self-incurred liability to defensive harm and, as a result, cannot be considered wrongful.

5.3 Addressing RQ1

Making it all come together, Paper B provides a direct response to RQ1, which asks: To what extent should responsibility-sensitive healthcare resource allocation be considered (wrongfully) discriminatory?, focusing specifically on how two types of responsibility-sensitive healthcare policies fare against seminal accounts of direct and harmful discrimination. Overall, both types of policies in question were found to constitute instances of direct discrimination. However, the two types differed in the conclusions drawn regarding their ability to deal successfully with the criticism of wrongful, and more specifically harmful, discrimination. Based on this, it seems reasonable to argue that GOs can handle accusations of wrongful discrimination more efficiently, potentially exceeding their proponents' expectations. In fact, although they were proposed in response to concerns about the difficulty of attributing causality and, consequently, identifying the truly imprudent, they seem capable of achieving even more. Building on all these, what the above argumentation implies is that:

a. We should be aware of one's personal responsibility for their poor status before classifying a case of differential treatment on those grounds as harmfully discriminatory as this information was proven able to reverse our verdict.
b. When applied, responsibility-sensitive healthcare resource allocation is both directly and harmfully discriminatory. Yet, the negative moral weight of that could be mitigated by people's potential self-incurred liability to defensive harm to such an extent that it would eventually be considered justified. Thus, when the individual targeted by responsibility-sensitive healthcare policies is found to be liable to defensive harm, discrimination indeed occurs, but merely in a non-moralised sense.

5.4 Further Reflections

As an endnote to Chapter 5, we should also reflect on the following points. First, it is worth considering alternative understandings of moral responsibility beyond the one I adopt and the potential implications of these for my argumentation. More specifically, I adopt the Fischer and Ravizza (1998) account of moral responsibility as it constitutes one of the most, if not the most, frequently cited accounts in the bioethics literature. Yet, scholars have also introduced alternative accounts, such as a McMahanian understanding of moral responsibility (McMahan, 2005; 2011). Under that, responsibility is operationalised as a continuum, with people being more or less morally responsible for a specific outcome. Key factors that determine one's responsibility and the degree of that include:

a. Causation: Did the agent contribute to or cause a specific outcome? Could this be attributed to their agency?
b. Knowledge and Intention: Was the agent able to foresee the likely consequences of their actions? Did they have sufficient information for that?
c. Existence of Reasonable Alternatives: Could the agent have acted/behaved differently?
d. Proportionality: What was the extent of the agent's contribution and the magnitude of the eventual (negative) outcome?

Even though this account does not explicitly invoke the control condition, key factor (c) brings similar sentiments to the table when it argues that the agent should also be able to act differently, implying some control over the situation, and potentially leads us to similar conclusions as the ones stated above. Yet, under this gradualist understanding of responsibility, it sounds more plausible for the imprudent to be found morally responsible for imposing an

objectively unjustified harm on others compared to the Fischer and Ravizza approach. However, the employment of this account would raise a new round of questions about the required amount of responsibility so that liability to defensive harm and, consequently, the justifiability of the differential treatment occurring under RSHPs could be grounded in that.

Another aspect worth reflecting on relates to the applicability and generalisability of GOs. It must be acknowledged that the general applicability of this specification has been questioned. In essence, the provision of a GO to smokers might seem plausible, and a number of countries already try to incentivise smokers to adopt alternative lifestyles with similar value but fewer risks than the current one, without, however, holding those who decide to keep acting recklessly responsible. Yet, it seems complicated to suggest what a realistically adoptable alternative with equal, or at least similar, health and non-health-related value, but fewer risks, would look like in cases such as obesity, alcoholism, or extreme sports. In all these cases, an alternative lifestyle could be associated with fewer risks, but it would also inescapably have lower value.

Finally, an equally interesting question to the ones addressed in Paper B is whether RSHPs and GOs are also cases of indirect discrimination. Indirect discrimination occurs when an allegedly neutral policy has a disparate impact on specific groups, such as socially disadvantaged individuals, people of a particular age or gender, and others (Lippert-Rasmussen, 2013). Furthermore, a policy or action cannot be both directly and indirectly discriminatory against the same group simultaneously (Lippert-Rasmussen, 2013). Therefore, it has already been indicated that RSHPs and GOs engage in direct discrimination against those who are imprudent and those who reject the provided offer, respectively. Yet, it could be also argued that since unhealthy behaviour is statistically more likely among those with lower socioeconomic status (Capellen & Norheim, 2005; Feiring, 2008; Pillutla et al., 2018), RSHPs and GOs could eventually have a disparate impact on people who were not truly responsible for their choices or do not really have the option of adopting an alternative healthier lifestyle. To demonstrate why this is not the case under either type of policy, consider the following. First, regarding RSHPs, it probably suffices to state that a truly luck egalitarian policy will treat only those who are truly imprudent differentially, rather than those heavily affected by external factors when it comes to their health-related choices. From this perspective, an RSHP in principle would not have a disparate impact on groups that appear imprudent but are not actually responsible for their poor choices. Second, regarding GOs, the proposed alternative lifestyle is, by definition, realistically adoptable and highly personalised, tailored to the patient's personal peculiarities or constraints for increased choosability. As a result, no disparate impact is expected to occur to the detriment of even the most disadvantaged individuals.

Chapter 6: Is Perceived Wrongful Discrimination Responsibility-Sensitive?

As illustrated in the previous chapters, Paper A and Paper B set the scene theoretically, sketching a viewpoint supportive of the consideration of personal responsibility when healthcare resource allocation is addressed. Paper A argued in favour of the responsibilisation of the healthcare system, defending that against respect-based objections and proving that a responsibility-sensitive healthcare system promotes rather than undermines (self-)respect. Along similar lines, Paper B moved one step forward and tested how certain types of responsibility-sensitive healthcare policies fare against seminal accounts of (wrongful) discrimination. Building on that test, it advocated that moderate responsibility-sensitive healthcare policies can avoid concerns about harmful discrimination and seem justified because of that, at least from a discrimination-based perspective.

Taking these theoretically formulated claims into account, Paper C examines whether they are equally shared among laypeople. In other words, it examines whether laypeople perceive cases of responsibility-sensitive healthcare and welfare provision as (wrongfully) discriminatory, aiming to provide a response to RQ2 that asks the following: Is perceived wrongful discrimination responsibility-sensitive? Unpacking laypeople's perceptions regarding this question is critical. Such insights can support but also challenge our theoretical assumptions and help us determine the degree of public support or resistance to policies that build on them. This can then shape the latter's social legitimacy and indicate whether policymakers and health professionals are justified in acting accordingly.

The chapter develops as follows. First, I unpack the theoretical background, hypotheses, and design of the experiment reported in Paper C, i.e., of an ethically approved and preregistered cross-country survey vignette experiment conducted among a representative sample of British (N = 2,014) and Danish (N = 2,003) participants. Then, I discuss key findings of the experiment and provide a direct response to RQ2. Finally, I engage with further reflections. Overall, Paper C employed an experimental philosophical approach, which uses experimental methods of social sciences to challenge, confirm, or explore questions and theoretical frameworks typically associated with philosophy (Knobe & Nichols, 2017; Nadelhoffer & Nahmias, 2007). After all, elaborating on how laypeople perceive the studied issues and whether their

perceptions diverge from the prevalent philosophical intuitions put forward a desideratum for theoretical reflection. It also fosters communication and mutual understanding between scholars and the public, while increasing the practical relevance of the formers' proposals and recommendations.

6.1 Theoretical Background

Studies from the last 20 years have highlighted that the majority of the public perceives individuals as mainly responsible for the preservation and promotion of their health, urging for greater personal accountability, at least as far as the healthcare context is concerned (Cavallero, 2011; Wellings, 2017; Holt-White, 2019; Bringedal & Rø, 2024; Schaeffer & Larsen, 2023; Schuessler et al., 2022). Building on that, the current study empirically tests whether the consideration of personal responsibility for one's current need and condition regarding their health and employment status as an allocation criterion is perceived as wrongfully discriminatory. In essence, what this study actually does is that it brings two different groups of literature in close contact, namely the discrimination literature and the luck egalitarian, desert/ deservingness, and immutability literatures, which, even though terminologically different, build around the same concern about whether responsibility should be a morally relevant property whenever cases of distribution or differential treatment are considered.

To unpack the core claims of the invoked pieces of literature and the gap in the literature addressed with this study, consider the following. On the one hand, as also extensively discussed in § 2.1, discrimination is the disadvantageous differential treatment of the other who belongs to a salient group that has or is believed to have some particular features (Lippert-Rasmussen, 2013). On the other hand, luck egalitarianism, as also illustrated in § 2.2, constitutes the responsibility-sensitive theory of distributive justice which argues that it is bad if some people are worse off than others for reasons that lie beyond their control, ascribing significant importance to the distinction between outcomes attributed to personal choices and those attributed to pure chance (Dworkin, 1981; Arneson, 1989; Cohen, 1989). Along similar lines, the desert/deservingness theory claims that people assess the justice of life chances and social benefits distribution based on criteria that suggest how deserving a person is. Intuitively adopting such a mindset, people support benefits for the victims of uncontrollable incidents, who are subsequently more deserving of help, and object to benefits for those with self-inflicted poor (health or employment) conditions (Kagan, 2012; Jensen & Petersen, 2017; Petersen, 2012; van Oorschot, 2000). Finally, following the immutability literature, the quality of specific characteristics as immutable ones, i.e., accidents of birth, is the one that entails the distinctively discriminatory wrongness of differential treat-

ment on these grounds (Clarke, 2015; Serafin, 2020; Thomsen, 2013; Taylor & Taylor, 2020).

The above-sketched viewpoints are controversial, and several scholars advocate for the exact opposite perspective, namely that responsibility or deservingness should not be taken into account and that the mutability or immutability of a specific feature is not a morally relevant quality when cases of distribution or differential treatment are assessed (Serafin, 2020; Malleson, 2018; Clarke, 2015; Feiring, 2008; Andersen & Nielsen, 2016; Levy, 2019; Fleurbaey, 1995; Anderson, 1999; Wolff, 2010; Cavallero, 2011; Jensen & Petersen, 2017; Moles, 2018). Building on the responsibility-sensitive angle of this debate and aiming to bridge the identified gap, the first hypothesis of the study in question states the following:

> *H1: Perceived wrongful discrimination is higher when personal responsibility for one's current condition is lower.*

Yet, both sides of the controversy seem to suggest that one size fits all cases, to wit, that responsibility either does or does not have an effect on laypeople's perception of wrongful discrimination, regardless of any context or individual-related differences. But is this indeed the case, or could people's country of origin, their culture, different domains, and the possibility of experiencing the same need and/or condition as the vignette subject moderate the relationship between responsibility and perceived wrongful discrimination? After all, self-interest literature argues that those who are currently recipients of welfare benefits and support, or at risk of becoming recipients, are more supportive of those benefits than those who are less likely to need them (Blekesaune & Quadagno, 2003; Hasenfeld & Rafferty, 1989; Jæger, 2006). Therefore, to address this concern, the study in question also engages with the following hypothesis:

> *H2: The effect of personal responsibility on perceived wrongful discrimination is smaller among those who experience the same need/condition.*

6.2 Justification of Research Design, Methods, and Key Choices

Paper C engages with an online cross-country survey vignette experiment. The latter was conducted among a representative sample of British and Danish participants, aiming to unpack the relationship between personal responsibility and perceived wrongful discrimination and answer the overarching question of whether perceived wrongful discrimination is responsibility-sensitive.

Before presenting the study's design, the decision to engage in comparative empirical research with participants from the UK and Denmark should be justified. Basically, given the divergent welfare systems of the two countries (UK: liberal welfare system vs Denmark: social-democratic welfare system), their different extents of ethnic homogeneity (UK: low homogeneity vs Denmark: high homogeneity), and the way they have chosen to attribute responsibility (UK: individualistic understanding of responsibility vs Denmark: collectivist understanding of responsibility), a comparative collection and analysis of data coming from these two countries were expected to increase the generalisability of the study's inferences.

Moving forward and diving into the study's design, it included twelve different conditions. Participants were initially asked to respond to some introductory background questions, such as 'Have you been a regular smoker at any point in your life?' or 'Have you been unemployed during the last two years?' Their answers to those questions were used to map their lifestyle and employment status for testing H2. To test H1, participants were presented with two randomly assigned vignettes – one out of six for the healthcare and one out of six for the welfare domain – in random order, and based on that, they were asked to assess the statement: 'The committee's decision to exclude this person was unfairly discriminatory' (= outcome variable).[3] Their responses were measured using a 7-point Likert scale (1: 'Strongly Disagree', 7: 'Strongly Agree').

Before unpacking how each group of vignettes varied, the choice of the healthcare and welfare domains should be justified. First, regarding the selection of healthcare as the focal case of this project, this has already been justified since the introduction of this summary. In brief, health and access to healthcare are perceived to be of exceptional intrinsic and instrumental value and therefore constitute crucial cases to be studied concerning responsibility

3. Even though, the study examined one outcome variable, perceived wrongful discrimination, participants were actually asked to evaluate three different statements. More specifically, they were asked to assess the extent to which the committee's decision to exclude the agent in question was wrong, discriminatory, and/or unfairly discriminatory. Assessments for the first two statements were grouped into an additive item. The reason why two different items were used relates to the investigator's uncertainty about laypeople's understanding of discrimination and how, if so, it differs from the philosophical one that distinguishes between neutral and wrongful discrimination. However, since the two items were found to be strongly correlated (r between 0.85 and 0.88 across all the experimental conditions) and it was assumed that participants would grasp better the meaning of wrongful discrimination under the item measuring 'unfair discrimination,' Paper C exclusively reported findings regarding this one.

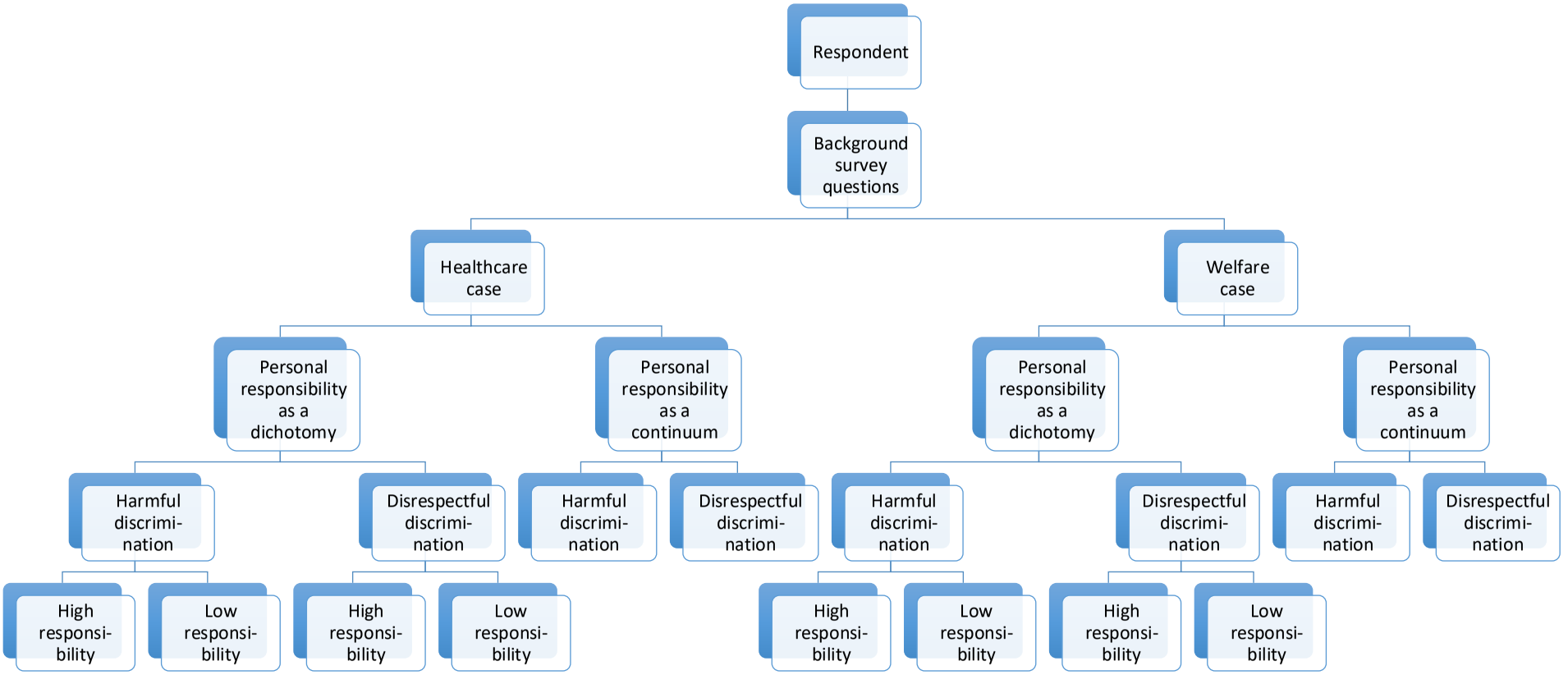
considerations. Adding to that, the invocation of a second case, and more specifically, of the welfare case, could be justified on the basis of helping us better understand the healthcare findings and how the detected effects travel to other domains. All things considered, the two domains present some similarities, such as internal variation – i.e., people may be more or less responsible for their current health and employment status – or that they are both found at the focal point of contemporary welfare states because of their critical effect on citizens' lives (Jensen & Petersen, 2017). At the same time, however, they also present some differences since health and access to healthcare are often perceived to be of special value, and thus one's deservingness is not usually employed in this context (Jensen & Petersen, 2017). These similarities and differences ensure the generalisability of the study's inferences.

Returning to the study's design, the healthcare vignettes differed in two key respects. The first concerned how responsibility was operationalised: either dichotomously, depicted as high vs low, or continuously through a randomly assigned percentage between 1 and 100. The second respect concerned the type of wrongful discrimination invoked in each scenario, namely harmful or disrespectful. The welfare vignettes also varied accordingly. Overall, the study design looked graphically like **Figure 1** on the next page.

Finally, to give the reader an idea of what those vignettes looked like, consider the following example of the dichotomous healthcare vignette when wrongful discrimination was understood as harm-based (please see Appendix A of Paper C for the full material):

> Consider a scenario in which several individuals are on the organ transplant waiting list of a hospital. Each patient would benefit equally from getting a transplant. However, one patient is informed by the hospital's committee that he will not receive an available lung. The committee notes that this patient **is a lifelong voluntary smoker, and he is responsible for his current health condition (high responsibility).** / **has an accidental genetic mutation that is responsible for his current health condition (low responsibility).**

Figure 1. Visual representation of the study's design



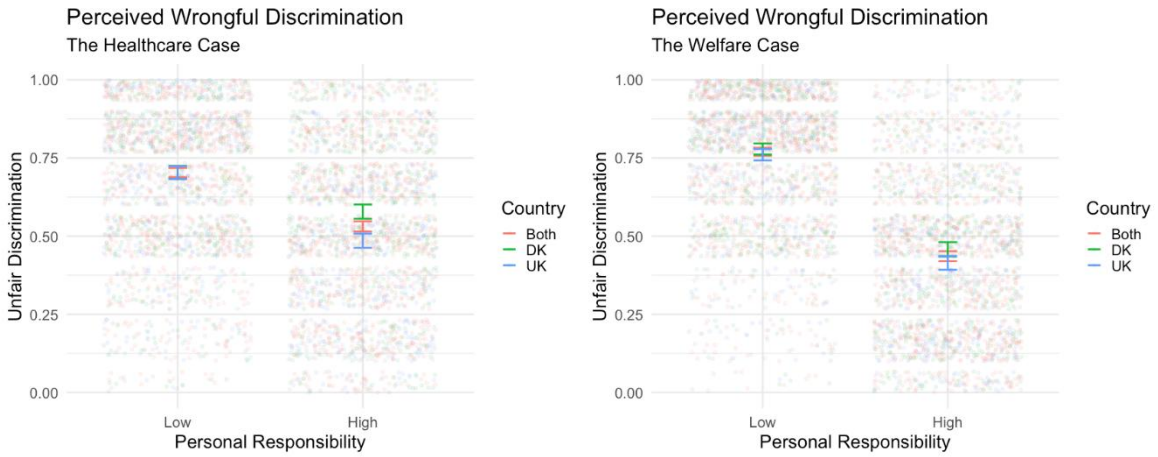
6.3 Results

Overall, the experimental findings provided supportive evidence for the already stated hypotheses of the study, indicating that the presence of personal responsibility for one's current condition or feature reduces perceived wrongful discrimination on that basis considerably regardless of the studied issue, participants' country of origin, discrimination's different understandings, or responsibility's different measures. However, variations among participants' responses under each of these conditions could also suggest laypeople's nuanced thinking about their relevant moral judgments by taking into consideration factors like the type of the issue in question and personal worries about their future. In what follows, I will cite representative examples of these findings that support the above claims.

H1 stated that 'Perceived wrongful discrimination is higher when personal responsibility for one's current condition is lower', and as **Figure 2** displays, both British and Danish subjects in the low responsibility case of healthcare and welfare resource allocation perceived the presented case as statistically significantly more wrongfully discriminatory than those exposed to the respective high responsibility cases. These results suggest that laypeople perceive instances of differential treatment as considerably less discriminatory when the discriminatee is (perceived as) responsible for the targeted feature or condition, which confirms H1.

There are at least three noteworthy aspects of these findings. First, H1 was supported irrespective of the issue or the participants' country of origin. The consensus regarding this finding could be explained through an evolutionary psychological understanding of deservingness, according to which people have evolved similarly, and as a result, employ the same deservingness heuristic when assessing social goods/benefits distributions and welfare policies (Jensen & Petersen, 2017; Petersen, 2012; Aarøe & Petersen, 2014). Second, even though participants classified the high responsibility cases as non- or neutrally discriminatory under most of the conditions, scoring below the 0.5 threshold, this finding was not consistent across all conditions, a variation that potentially suggests that personal responsibility influences perceptions of wrongful discrimination, but sometimes only to a moderate extent. Finally, revisiting the pre-existing literature and the controversy sketched in § 6.1, the presented findings appear to suggest a way out by arguing in favour of the luck egalitarian, desert/deservingness, and immutability viewpoints.

Figure 2. Mean scores for perceived wrongful discrimination across two domains (healthcare and welfare), levels of responsibility (low and high), and countries (pooled data frame, DK, UK)



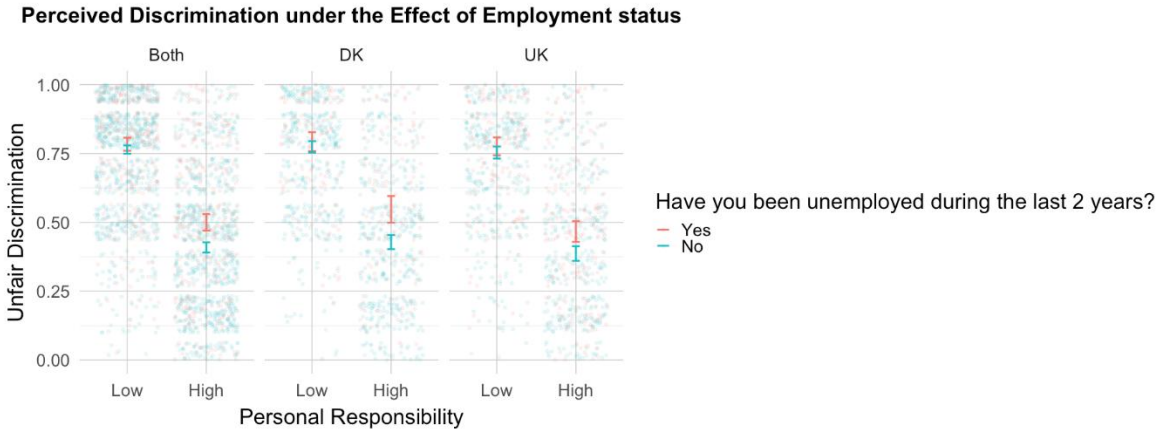
Note: Nhealthcare = 2,673 (pooled data frame), 1,331 (DK), 1,342 (UK). Nwelfare = 2,681 (pooled data frame), 1,338 (DK), 1,343 (UK). Error bars indicate 95% confidence intervals.

H2 stated that 'The effect of personal responsibility on perceived wrongful discrimination is smaller among those who experience the same need/condition' as the vignette subject. As **Figures 3 and 4** display, those participants, i.e., smokers and unemployed individuals, respectively, were indeed found to be less affected by the presence of personal responsibility when they were asked to indicate the extent to which they perceived the presented vignette of high responsibility as unfairly discriminatory. Building on that, this finding suggests that the effect of personal responsibility on the outcome variable of perceived wrongful discrimination is statistically significantly dependent on the respondents' smoking and employment status and, thus, considerations of self-interest, with a clearer effect, however, detected in the healthcare context. Consequently, H2 was confirmed. Yet, an additional finding must also be emphasised, i.e., that the statistically significant effect of personal responsibility on perceived wrongful discrimination stands even when people may be directly affected by the outcome of this discussion. Overall, these findings align with the pre-existing literature since they advocate for the point that current recipients of welfare state support, or those at risk of becoming recipients, are more supportive of these benefits than those who are less likely to receive them (Blekesaune & Quadagno, 2003; Hasenfeld & Rafferty, 1989; Nordlun, 1997; Jæger, 2006).

Figure 3. Perceived wrongful discrimination under the effect of smoking status across levels of personal responsibility and countries

Note: Nsmokers = 1,184 (pooled data frame), 666 (DK), 518 (UK), Nnon-smokers = 1,454 (pooled data frame), 657 (DK), 797 (UK). Error bars indicate 95% confidence intervals.

Figure 4. Perceived wrongful discrimination under the effect of employment status across levels of personal responsibility and countries

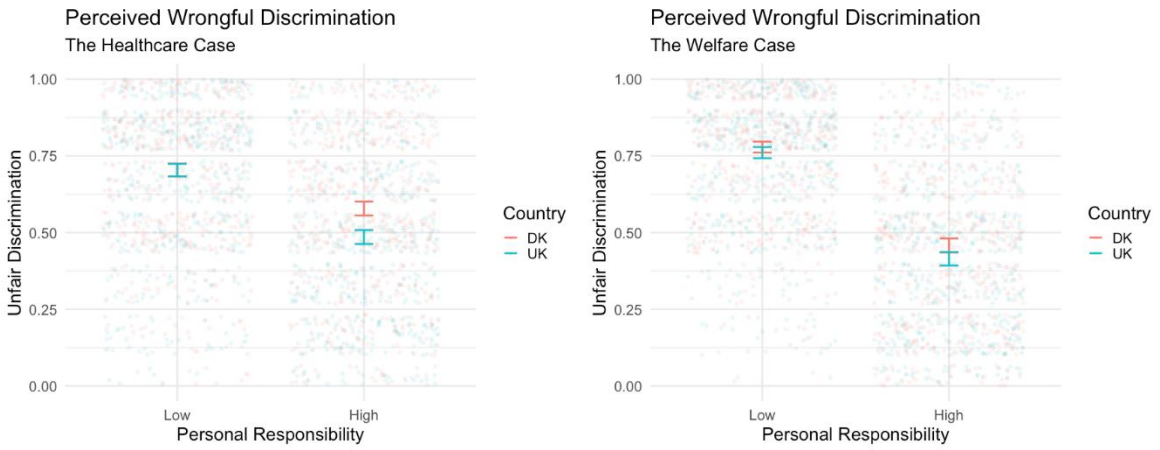


Note: Nemployed = 1,903 (pooled data frame), 1,002 (DK), 901 (UK), Nunemployed = 778 (pooled data frame), 336 (DK), 442 (UK). Error bars indicate 95% confidence intervals.

Finally, Paper C also engaged with a number of exploratory hypotheses. It is worth reporting two of them here. The first exploratory hypothesis asked whether there are any differences regarding the effect of personal responsibility on perceived wrongful discrimination between the two countries across the studied domains. As displayed in **Figure 5**, the pattern was the same in both countries, across all domains, namely perceived wrongful discrimination decreased when moving from low to high responsibility. Yet, it was also detected that the effect of personal responsibility was indeed moderated by country in the healthcare domain, given that the decrease of perceived wrongful discrimination was statistically significantly higher within the British sample com-

pared to the Danish one. Possible explanations behind this divergence include, among others, the type of the British welfare system, which is generally characterised by scepticism against redistribution; the UK's individualistic understanding of responsibility regarding neediness for healthcare provision; and the high levels of ethnic heterogeneity as opposed to Denmark's social-democratic welfare system, collectivist understanding of responsibility, and low levels of ethnic heterogeneity.

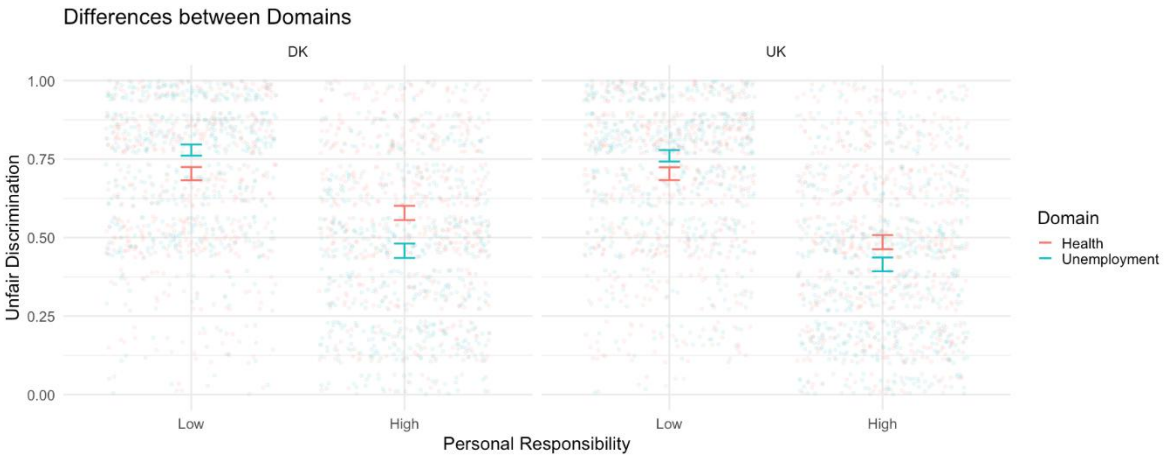
Figure 5. Differences in perceived wrongful discrimination between Denmark and the UK across two different domains (healthcare and welfare)



Note: Nhealthcare = 1,331 (DK), 1,342 (UK). Nwelfare = 1,338 (DK), 1,343 (UK). Error bars indicate 95% confidence intervals.

The second exploratory hypothesis asked whether there are any differences regarding the effect of personal responsibility on perceived wrongful discrimination between the two different domains – healthcare and welfare – across the two studied countries. As displayed in **Figure 6**, the effect of personal responsibility on perceived wrongful discrimination was indeed moderated by the domain under consideration. In both the UK and Denmark, the results suggested a statistically significantly larger reduction of perceived wrongful discrimination when moving from low to high responsibility in the welfare domain. Among others, probably the prevalent explanation of why this is the case relates to the special value people attach to health and access to healthcare, as well as their tendency to view healthcare recipients as more deserving of aid compared to other groups, like the unemployed (Jensen & Petersen, 2017).

Figure 6. Differences in perceived wrongful discrimination between the two domains (healthcare and welfare) across the studied countries (DK and UK)



Note: NDK = 1,331 (healthcare), 1,338 (welfare). NUK = 1,342 (healthcare), 1,343 (welfare). Error bars indicate 95% confidence intervals.

Finally, before reflecting on how Paper C addresses RQ2, I should revisit and elaborate on which of the X-Phi programmes – negative, positive, exploratory – this project aligns with and how. To refresh my readers' memory, the negative programme debunks the prevalent philosophical methodology of building on people's intuitions for theory development, highlighting that they are context dependent and, consequently, an unstable ground. In contrast to that, the positive programme sees some value in these intuitions for theory development, while the exploratory one directly investigates how people feel and think, i.e., their cognitive processes, rather than their feelings or thoughts about a specific issue. Taking this into account, the project clearly adheres to the positive programme given the value that it ascribes to laypeople's intuitions for resolving the theoretical conflict between those who suggest that responsibility should be a morally relevant quality whenever we assess cases of distribution or differential treatment and those who deny that. Furthermore, it also partially aligns with the exploratory programme since it examines whether people's intuitions are indeed affected by external factors like the type of the studied issue, their country of origin, their cultural identity, as well as their personal concerns about the future, and concludes that they do.

6.4 Addressing RQ2

Making it all come together, Paper C provides a direct response to RQ2, which asks: Is perceived wrongful discrimination responsibility-sensitive? The reported findings support an affirmative response to this question since they firmly argue for the conclusion that the presence of personal responsibility for one's current condition or feature considerably reduces perceived wrongful

discrimination on these grounds across several conditions. Put that differently, when personal responsibility is present, laypeople are much more willing to accept differential treatment or inequalities on that basis, at least in the healthcare and welfare contexts, across a number of conditions, like the participants' country of origin, their personal considerations, or the kind of the studied domain. However, some variation among participants' responses under different conditions was also observed. A possible explanation of that could relate to laypeople's nuanced thinking and careful deliberation about their relevant moral judgments, reckoning with considerations about a number of factors. Thus, building on all these claims, one could argue that differential treatment against features for which individuals could be held accountable for appears to be justified and need not be eliminated (~ luck egalitarianism). Along similar lines, differential treatment grounded in varying degrees of deservingness, stemming from individuals' efforts to escape their poor condition, seems equally justified (~ desert/deservingness). Similarly, the immutable nature of certain characteristics was identified as the factor that renders differential treatment on such grounds distinctively wrongful (~ immutability). Therefore, perceived wrongful discrimination appears indeed to be responsibility-sensitive. Yet, we should remain mindful of the fact that the coherence between theory and laypeople's intuitions is not always considered a decisive desideratum.

6.5 Further Reflections

As an endnote to Chapter 6, we should also reflect on the following points. First, all things considered, the reported study and findings also face some limitations. As mentioned in § 6.2, the study also operationalised the responsibility variable as a continuous one under some vignettes. However, the sample size of participants exposed to these vignettes and the different percentages of responsibility was limited, undermining the statistical power and significance of the relevant findings. For that reason, those findings are not reported here. Yet, it is probably noteworthy that they follow the same patterns suggested by the results of the dichotomous vignettes. Additionally, only a limited variation of cases and domains was employed by the study's vignettes. Because of that, the generalisability of the stated inferences to other health- or welfare-related issues and conditions and other domains is questionable. For example, prior findings suggest that laypeople usually perceive smoking- and obesity-related conditions less as a disease and therefore as less deserving of help (Jensen & Petersen, 2017). Something like that could have an undetected effect on the current study's respondents and their perception of wrongful discrimination, limiting the generalisability of the respective findings to other cases. Finally, as also mentioned in § 6.2 and footnote 3, there is some

uncertainty regarding laypeople's understanding of discrimination. Does their understanding align with the philosophical one, which distinguishes between neutral and wrongful discrimination, or do they adopt a moralised understanding of that? To avoid any confusion, I employed two different items to measure the same outcome variable and use the term 'unfairly discriminatory' instead of the scholarly established term of 'wrongfully discriminatory' that would probably be perceived as a meaningless tautology from those who eventually understand discrimination as a morally objectionable concept per se.

However, this study's findings could eventually provide a way out of the just articulated confusion. As mentioned above and in § 6.2, two different items were employed in the study to measure the same outcome variable. The first item was an additive one combining the results of people's assessments of the following statements: a) 'The committee's decision to exclude this person is wrong', and b) 'The committee's decision to exclude this person is discriminatory'. The second item operationalised discrimination as a morally objectionable concept per se, depicting people's assessments of the statement: 'The committee's decision to exclude this person is unfairly discriminatory'. Given the strong correlation between the two items (r between 0.85 and 0.88 across all the experimental conditions), it is reasonable to suggest that overall, laypeople adopt a moralised understanding of discrimination.

Finally, the above findings can also provide interesting insights to an additional literature, i.e., 'the new politics of welfare state' one introduced by Paul Pierson (1996). In brief, this literature reflects on the crisis that the contemporary welfare states of the developed world have been experiencing since the second half of the 20th century and their consequent focus on policies of retrenchment rather than expansion. Retrenchment is politically challenging to implement due to entrenched popular support and institutional constraints. This realisation explains why most governments use blame avoidance and implement moderate cuts in less visible ways, like indexing benefits to inflation rather than implementing direct reductions or generally attributing these to factors beyond their control. The above findings and the preexisting literature, which suggests public support for the responsibilisation of healthcare and welfare provision, could be helpful for policymakers in pressing need of justification of specific cuts or reductions. However, further research is needed to investigate whether the presence of personal responsibility affects people's viewpoints about benefits withdrawal similarly to when it comes to their perceptions about benefits allocation.

Chapter 7: Conclusion and Final Reflections

In the previous chapters, I have shown that in principle, a responsibility-sensitive healthcare system promotes (self-)respect instead of undermining it. By depicting the disadvantageous differential treatment of the imprudent merely as a side effect of a system that aims to bring about some good overall and by building on a perspective according to which we have an inescapable duty to ourselves and others to preserve our health, a responsibility-sensitive healthcare system is portrayed as a facilitator of respect as opposed to what the respect-based family of objections argues. Having established that theoretically, I turn my focus to responsibility-sensitive applications, remaining, however, within the healthcare context. More specifically, I subject specific types of responsibility-sensitive healthcare policies – a hardcore and a moderate one – to the direct and harmful discrimination test. Based on how they fare against seminal definitions of direct and harmful discrimination, I conclude that only moderate policies, like GOs, manage in practice to escape the recently raised critique of discrimination.

Finally, I direct my interest out in the real world to examine whether those intuitions and inferences are equally shared by laypeople, namely whether the presence of responsibility for the targeted feature considerably affects their perception of what counts as wrongful discrimination and when this occurs. By conducting a cross-country survey vignette experiment among a representative sample of British and Danish participants, I conclude that laypeople are more willing to accept differential treatment on the grounds of a feature for which the discriminatee is responsible. This finding implies that perceived wrongful discrimination is responsibility-sensitive and confirms the responsibility-sensitive angle of the relevant theoretical debate. Yet, variation among participants' responses also hint that there is more than what is captured by the theory. One's culture, country of origin, personal concerns, or the type of issue being studied seem to moderate the effect of responsibility on perceived wrongful discrimination. Consequently, even though laypeople support a responsibility-sensitive mindset, no size seems able to fit all cases!

Building on the above, we also need to revisit the dissertation's sub- and overarching RQs and indicate explicitly what the dissertation's papers state in response to these. To remind the reader, the overarching RQ asks the following: *What should the role of personal responsibility be, and how is it perceived regarding assessments of (wrongful) discrimination?* The sub-RQs ask the following:

- RQ1: To what extent should responsibility-sensitive healthcare resource allocation be considered (wrongfully) discriminatory?
- RQ2: Is perceived wrongful discrimination responsibility-sensitive?

Starting with RQ1, Papers A and B directly deal with that question. More specifically, Paper A defends responsibility-sensitive healthcare resource allocation against the respect-based family of objections, i.e., the harshness, intrusiveness, and disrespectful discrimination critiques. Essentially, it argues that a responsibility-sensitive healthcare system promotes instead of undermines (self-)respect and, consequently, does not constitute an instance of disrespectful discrimination. Adding to that, Paper B concludes that certain types of responsibility-sensitive healthcare policies, to wit, the moderate ones, escape the criticism of harmful discrimination. Put differently, even though direct discrimination and some extent of harm is imposed on the imprudent, this is of the justified kind given the accurately determined liability to defensive harm of the imprudent. All in all, a responsibility-sensitive viewpoint and its applications in healthcare indeed engage in direct discrimination against the imprudent since they argue for a disadvantageous differential treatment to their detriment because of their imprudence. Yet, this is neither disrespectful nor unjustly harmful.

Similarly, Paper C deals with RQ2. In response to that, it shows that laypeople's perception of wrongful discrimination is indeed responsibility-sensitive as laypeople are much more willing to classify differential treatment cases based on a feature for which the 'discriminatee' is (perceived as) responsible as less wrongfully discriminatory or even neutrally discriminatory.

Overall, as regards the overarching RQ, the above indicate that:

a. theoretically and in practice, personal responsibility appears able to justify the occurrence of disadvantageous differential treatment on the basis of a feature the 'discriminatee' bears responsibility for, at least in the healthcare context, provided that certain additional conditions, like the employment of merely moderate policies, are satisfied; and
b. the presence of personal responsibility for the targeted feature considerably reduces perceived wrongful discrimination across several conditions, implying that personal responsibility for the targeted feature plays the role of a moderator regarding laypeople's assessment of what counts as wrongful discrimination and when this occurs.

7.1 Contributions

Before reflecting on this endeavour's limitations and avenues of further research, I should highlight the multilevel contributions of this dissertation and how they materialised.

First, from a theoretical point of view, the dissertation's theoretical and empirical claims and findings shed new light on various literatures and introduce a novel argument in defence of responsibility-sensitivity within healthcare and potentially other sectors as well. All things considered, a supportive line of argument in favour of luck egalitarianism was put forward since it was proven that the consideration of personal responsibility regarding resource allocation under conditions of scarcity is both theoretically and empirically justified from a discrimination-based perspective. In addition to that, a novel deontological argument in support of responsibility-sensitivity was introduced, further strengthening the usually raised distributive justice-based arguments.

However, as Chapter 6 suggested, those theoretically and empirically grounded inferences also have implications for other literatures, like the desert/deservingness and the immutability literatures, which, although terminologically different, build around the common concern about the moral relevance of responsibility whenever cases of distribution or differential treatment are assessed. As regards these pieces of literature, my dissertation seems to advocate that differential treatment because of different degrees of deservingness based on people's efforts to escape their poor condition is justified (~ desert/deservingness), and that the immutable character of certain features is eventually the one that determines the distinctively discriminatory wrongness of differential treatment on these grounds (~ immutability). Lastly, the dissertation also contributes directly to the discrimination theory. In essence, it points to the direction of revisiting and slightly revising prevalent definitions of discrimination and what makes it wrongful, keeping responsibility-sensitivity in mind.

Second, the dissertation, and particularly Paper B, could also relate to a more applied contribution. More specifically, by subjecting already implemented or proposed types of responsibility-sensitive healthcare policies to the test of direct and harmful discrimination, to wit, by examining how these types of policies fare against seminal definitions of direct and harmful discrimination, Paper B identified and argued for the justifiability of the specific type of policies that successfully passes the test, i.e., moderate policies, like GOs. This inference could have more practical implications by requesting the reform of already implemented policies that fail this test or their replacement, as well as by determining the type of policies that should be implemented should

responsibility be considered an allocation criterion, at least from a discrimination-based point of view.

Finally, the empirical/experimental philosophical contributions of the dissertation should also be highlighted. First, the reported study in Chapter 6 and Paper C is the first of its kind, to the author's knowledge, that focuses on the intersection of the discrimination and the luck egalitarian literatures by unpacking laypeople's perceptions of wrongful discrimination when personal responsibility for the targeted feature is present. Adding to that, this study introduced an innovative way of depicting the responsibility variable. In essence, even though the luck egalitarian and the desert/deservingness literatures seem to approach responsibility and the subsequent deservingness as continuous variables, with people being depicted as more or less responsible or deserving and not as either responsible or not, relevant empirical studies operationalise the responsibility variable as a dichotomous one. In contrast to that, the current study takes that understanding into account and portrays responsibility not only as a dichotomous variable but also as a continuous one under some vignettes. Second, this dissertation empirically tests and confirms a specific angle of the theoretical controversy of whether the consideration of personal responsibility as an allocation criterion creates and exacerbates discrimination dynamics. Essentially, it argues in favour of the justifiability of that consideration from a discrimination-based viewpoint. However, it moves one step further to reveal that even though the responsibility-sensitive perspective seems to capture laypeople's intuitions more accurately, the whole picture is much broader than what this literature suggests since laypeople's relevant moral judgments appear to be much more context dependent and influenced by personal characteristics. Yet, it remains questionable whether the philosophical literature should pay any attention to those intuitions.

7.2 Limitations

In this sub-section, I reflect on some limitations of the dissertation. First, Papers A and B lack more applied or context-specific considerations, respectively, whereas Paper C encounters several limitations associated with the financial and time constraints that every empirical study faces. Moreover, the whole dissertation focuses on backward-looking responsibility-sensitive policies that hold the imprudent responsible for their causal contribution to their current poor state of affairs. Yet, what about forward-looking policies that hold individuals responsible for their intended future outcomes? Could the above inferences apply to them too? Further research is required for a definitive response to these questions. However, to justify my choice not to discuss this kind of policies, let me mention that I adopt Andreas Albertsen's viewpoint, according to which even under allegedly forward-looking policies, the

action or behaviour for which the imprudent will eventually be held responsible will have taken place in the past, also rendering those policies backward-looking (Albertsen, 2015). Additionally, even though the project engages with certain types of responsibility-sensitive healthcare policies to a certain extent, it does not assess specific policies, like the British 'fitness for surgery' policy, or the one implemented under the German statutory insurance scheme. Further research is also needed to test whether the more abstract inferences of this dissertation can also apply to specific implementations of the responsibility-sensitive perspective.

Furthermore, mainly because of time constraints, the project employed exclusively quantitative methods, specifically a survey vignette experiment. Other methodological approaches, like qualitative research and particularly interviews with experts, like doctors and bioethicists, could potentially help me unpack further insights and even lead to different conclusions than the ones drawn based on the survey experiment's results. In parallel, the validity of the above claims and inferences stands exclusively within the context of the Western/developed world. The rest of the world is often characterised by health illiteracy, financial constraints, a combination of communicable and non-communicable diseases, or a more collectivist mindset regarding people's interactions and the notion of responsibility, all factors that would question the applicability of the above discussions, arguments, and conclusions in this context. Nevertheless, investigating whether the above patterns are replicated or challenged by these populations bears undeniably significant value.

Finally, a critical scholar could question the very plausibility of bringing together the concepts of personal responsibility and discrimination and examining their relationship. Essentially, they could argue that personal responsibility constitutes a person-centred concept while discrimination a group-centred one, and the two are incompatible as a result. In response to this objection to the entirety of the above project, I must state that discrimination through the lens of an Eidelsonian account appears compatible with personal responsibility. More specifically, under Eidelson (2015), the social salience requirement should be rejected, and discrimination should be understood merely as the disadvantageous differential treatment against Y in respect of W compared to some actual or counterfactual other Z because of a difference in how the discriminator regards Y P-wise and how they regard or would regard Z P-wise, irrespective of any group-related criteria.

7.3 Further Research

In § 4.4, 5.4, 6.5, and 7.2, several avenues of further research have already been discussed. To gather them all here, but also point to additional directions, consider the following. First, in Chapter 4/Paper A, I introduced a novel

deontological argument in favour of responsibility-sensitivity. Yet, there is still room for further supportive argumentation that could, among others, build on utilitarian grounds. Adding to that, in the same paper, I merely examined my arguments' applicability regarding non-life-threatening resources. Yet, what about life-threatening resources? Could they also be considered under the proposed arguments?

Second, Chapter 5/Paper B advocated for moderate responsibility-sensitive healthcare policies, like GOs, as these, rather than conventional ones, successfully counter the discrimination-based objections. However, the following questions could be raised about this:

a. Is this inference equally shared by laypeople, and if so, for what reasons?
b. Would the invocation of more moderate policies in the context of a study increase the effect of personal responsibility on perceived wrongful discrimination?
c. What would other understandings of moral responsibility have to say about the current discussion, and could the invocation of a different notion of responsibility, like the one of distributive responsibility, provide a way out of the studied controversy much more easily?
d. Could the applicability of GOs to other cases, like alcoholism or extreme sports, be improved and how?

Adding to that, a more extensive reflection of the potentially indirectly discriminatory implications of these polices and a responsibility-sensitive healthcare allocation in general must take place.

Third, despite the insights reported in Chapter 6/Paper C, further research on laypeople's understanding of discrimination – do they perceive that as a morally objectionable concept per se or not – on the effect of responsibility when depicted as a continuous variable, and on whether these insights have anything to say about the 'new politics of welfare state' debate is needed. Finally, in a broader note, it remained unclear whether laypeople perceive individuals as responsible for their habits and behaviour or their subsequent poor health condition. My project never aimed to resolve this puzzle, but further research is needed to reveal additional aspects of laypeople's understanding of the notion of responsibility.

Adding to the above, § 7.2 highlighted the need for assessing specific and already implemented responsibility-sensitive healthcare policies to test whether the abstract claims and inferences of this project also apply to these or whether real-life factors and considerations make things more complex and less straightforward. In parallel, further research using qualitative methods is expected to add interesting insights to the discussion, unpacking the motiva-

tion and concerns behind experts' support or aversion to such measures. Similarly, the replicability of the aforementioned findings should be tested with a sample coming from the developing world or a culturally different community. For instance, Asian populations usually adopt a collectivist understanding of responsibility and are largely homogeneous. Based on that, running the same survey experiment with members of these populations is expected to provide findings closer to the Danish ones. Yet, it would be interesting to find out whether these cultural differences can nullify or completely shift the effect of personal responsibility on perceived wrongful discrimination.

Moreover, further research is required to determine whether the above claims and findings apply to other health- and welfare-related issues and domains. For example, would people's intuitions still hold regarding obese people and smokers' exclusion from publicly funded fertility treatments, or extreme athletes' deprioritisation or obligation to pay for receiving treatment under conditions of scarcity? Similarly, would these findings replicate when other features for which one can bear responsibility are addressed, like when appearance is considered in the recruitment process? Additionally, further research should focus on the potential effect that the framing of the current study could have on people's responses. To elaborate, it is worth examining whether it would make any difference if the vignettes were asking participants to picture themselves in the position of the rejected agent. Finally, alternative explanations behind the lower effect of personal responsibility on smokers' and unemployed individuals' perceptions of wrongful discrimination, except for concerns of self-interest, should be tested. It could be proven, for instance, that it was smokers' better understanding of the control the average smoker has over their condition and not personal concerns for their future that explains better the lower decrease in perceived wrongful discrimination when moving from low to high responsibility.

All in all, this project has made some clear and significant contributions to enhancing our understanding of the moral and empirical dimensions of personal responsibility in assessments of (wrongful) discrimination. However, it should also be seen as a point of departure since it opens numerous promising avenues for further inquiry that can deepen, challenge, and expand upon its findings.

Ἰθάκη
Ithaca

Σὰ βγεῖς στὸν πηγαιμὸ γιὰ τὴν Ἰθάκη,
As you set out for Ithaka
νὰ εὔχεσαι νἆναι μακρὺς ὁ δρόμος,
hope the voyage is a long one,
γεμάτος περιπέτειες, γεμάτος γνώσεις.
full of adventure, full of discovery.

Τοὺς Λαιστρυγόνας καὶ τοὺς Κύκλωπας,
Laistrygonians and Cyclops,
τὸν θυμωμένο Ποσειδῶνα μὴ φοβᾶσαι,
angry Poseidon—don't be afraid of them:
τέτοια στὸν δρόμο σου ποτέ σου δὲν θὰ βρεῖς,
you'll never find things like that on your way
ἂν μέν' ἡ σκέψις σου ὑψηλή, ἂν ἐκλεκτὴ
as long as you keep your thoughts raised high, as long as a rare
συγκίνησις τὸ πνεῦμα καὶ τὸ σῶμα σου ἀγγίζει.
excitement stirs your spirit and your body.

Τοὺς Λαιστρυγόνας καὶ τοὺς Κύκλωπας,
Laistrygonians and Cyclops,
τὸν ἄγριο Ποσειδώνα δὲν θὰ συναντήσεις,
wild Poseidon—you won't encounter them
ἂν δὲν τοὺς κουβανεῖς μὲς στὴν ψυχή σου,
unless you bring them along inside your soul,
ἂν ἡ ψυχή σου δὲν τοὺς στήνει ἐμπρός σου.
unless your soul sets them up in front of you.

Νὰ εὔχεσαι νά 'ναι μακρὺς ὁ δρόμος.
Hope the voyage is a long one.
Πολλὰ τὰ καλοκαιρινὰ πρωϊὰ νὰ εἶναι
May there be many summer mornings when,
ποὺ μὲ τί εὐχαρίστηση, μὲ τί χαρὰ
with what pleasure, what joy,
θὰ μπαίνεις σὲ λιμένας πρωτοειδωμένους·
you come into harbours seen for the first time;

νὰ σταματήσεις σ' ἐμπορεῖα Φοινικικά,
may you stop at Phoenician trading stations
καὶ τὲς καλὲς πραγμάτειες ν' ἀποκτήσεις,
to buy fine things,

σεντέφια καὶ κοράλλια, κεχριμπάρια κ' ἔβενους,
mother of pearl and coral, amber and ebony,
καὶ ἡδονικὰ μυρωδικὰ κάθε λογῆς,
sensual perfume of every kind—
ὅσο μπορεῖς πιὸ ἄφθονα ἡδονικὰ μυρωδικά.
as many sensual perfumes as you can;

Σὲ πόλεις Αἰγυπτιακὲς πολλὲς νὰ πᾷς,
and may you visit many Egyptian cities
νὰ μάθεις καὶ νὰ μάθεις ἀπ' τοὺς σπουδασμένους.
to gather stores of knowledge from their scholars.
Πάντα στὸ νοῦ σου νἄχῃς τὴν Ἰθάκη.
Keep Ithaka always in your mind.
Τὸ φθάσιμον ἐκεῖ εἶν' ὁ προορισμός σου.
Arriving there is what you are destined for.

Ἀλλὰ μὴ βιάζῃς τὸ ταξείδι διόλου.
But do not hurry the journey at all.
Καλλίτερα χρόνια πολλὰ νὰ διαρκέσει.
Better if it lasts for years,
Καὶ γέρος πιὰ ν' ἀράξῃς στὸ νησί,
so you are old by the time you reach the island,
πλούσιος μὲ ὅσα κέρδισες στὸν δρόμο,
wealthy with all you have gained on the way,
μὴ προσδοκώντας πλούτη νὰ σὲ δώσῃ ἡ Ἰθάκη.
not expecting Ithaka to make you rich.

Ἡ Ἰθάκη σ' ἔδωσε τ' ὡραῖο ταξίδι.
Ithaka gave you the marvellous journey.
Χωρὶς αὐτὴν δὲν θἄβγαινες στὸν δρόμο.
Without her you would not have set out.
Ἄλλα δὲν ἔχει νὰ σὲ δώσει πιά.
She has nothing left to give you now.

Κι ἂν πτωχικὴ τὴν βρῇς, ἡ Ἰθάκη δὲν σὲ γέλασε.
And if you find her poor, Ithaka won't have fooled you.
Ἔτσι σοφὸς ποὺ ἔγινες, μὲ τόση πείρα,
Wise as you will have become, so full of experience,
ἤδη θὰ τὸ κατάλαβες ἡ Ἰθάκες τί σημαίνουν.
you will have understood by then what these Ithakas mean.

Κ. Π. Καβάφης, 1911
C. P. Cavafy, 1911

English Summary

When smokers are denied access to publicly funded fertility treatments like IVF, does this constitute discrimination? When obese patients with a BMI over 30 are requested to lose some weight before they are considered eligible for elective surgery, are they justified in claiming that they are subject to discrimination? Motivated by such questions, this dissertation addresses the overarching research question: *What should the role of personal responsibility be, and how is it perceived regarding assessments of (wrongful) discrimination?* Focusing on the examination of the potentially discriminatory character of responsibility-sensitive healthcare resource allocation and the responsibility-sensitivity of lay perceptions of wrongful discrimination, the dissertation advances the following three central claims: a) a responsibility-sensitive healthcare resource allocation is not disrespectfully discriminatory; b) when this is realised with moderate measures, it can also escape concerns about harmful discrimination; and c) perceived wrongful discrimination is responsibility sensitive, i.e., when someone is (perceived as) responsible for a feature, differential treatment on these grounds is regarded as much more justified than differential treatment targeting immutable traits.

The dissertation employs a mixed-methodology approach combining normative and experimental-philosophical analysis. First, it unpacks the justice-based discussion about the morally relevant quality of personal responsibility when distributive justice (in healthcare) is assessed, and it standardises the discrimination critique, often employed but never elaborated on, against luck egalitarianism, the responsibility-sensitive theory of distributive justice. Building on that, it introduces a novel line of deontological arguments in support of a responsibility-sensitive healthcare resource allocation against the respect-based family of critiques, namely the harshness, intrusiveness, and discrimination critiques. By arguing that the differential treatment of the imprudent merely constitutes a side effect of a morally permissible action in our effort to bring about some good and that we have an inescapable duty to ourselves and others to preserve our health, it reintroduces responsibility-sensitive healthcare resource allocation as a promoter, rather than an underminer, of (self-)respect.

Furthermore, the dissertation explores in more applied terms how specific types of responsibility-sensitive healthcare policies, to wit, the conventional backward-looking type of these (RSHPs) and their specification built around the idea of Golden Opportunities (GOs), fare against seminal definitions of direct and harmful discrimination. By invoking a potentially mitigating

argument grounded in the concept of liability to defensive harm, it further argues that although both types of policies adhere to the cited definitions, the moderate one, i.e., GOs, manages to escape concerns of harmful discrimination and, consequently, appears justified. Finally, based on an ethically approved and preregistered cross-country vignette survey experiment among a representative sample of British and Danish respondents, it is demonstrated that perceived wrongful discrimination is responsibility-sensitive, at least in the context of healthcare and welfare provision. In other words, it is found that the presence of responsibility for the targeted feature determines, to a considerable extent, which cases of differential treatment people classify as wrongfully discriminatory. The more responsible for the targeted trait a person is depicted to be, the less morally objectionable the occurrence of differential treatment on that basis is perceived to be across several conditions, like one's country of origin, culture, kind of the studied domain, and even personal considerations regarding one's probability to experience a similar need as the vignette subject.

Overall, this dissertation significantly contributes to our understanding of the moral and empirical dimensions of personal responsibility in assessments of (wrongful) discrimination. Rather than a conclusion, however, it establishes a foundation upon which further research can build, deepening, challenging, and broadening the insights developed here.

Dansk Resumé

Når rygere nægtes adgang til offentligt finansierede fertilitetsbehandlinger, såsom IVF, udgør dette så diskrimination? Når overvægtige patienter med BMI over 30 bliver bedt om at tabe sig, før de kan komme i betragtning til elektiv kirurgi, er det så berettiget, at de hævder, at de udsættes for diskrimination? Motiveret af sådanne spørgsmål behandler denne afhandling det overordnede forskningsspørgsmål: Hvilken rolle bør personlig ansvarlighed spille, og hvordan opfattes den i forbindelse med vurderinger af (uretmæssig) diskrimination? Med fokus på undersøgelsen af den potentielt diskriminerende karakter af ansvarlighedsorienteret fordeling af sundhedsressourcer og ansvarlighedsorienteringen i lægfolks opfattelse af uretmæssig diskrimination fremsætter afhandlingen følgende tre centrale påstande: a) en ansvarlig fordeling af sundhedsressourcer er ikke respektløst diskriminerende; b) når dette realiseres med moderate foranstaltninger, kan det også undgå bekymringer om skadelig diskrimination; og c) opfattet uretmæssig diskrimination er ansvarlig, dvs. når nogen er (opfattes som) ansvarlig for en egenskab, betragtes forskelsbehandling på dette grundlag som langt mere berettiget end forskelsbehandling, der er rettet mod uforanderlige træk.

Afhandlingen anvender en blandet metodologi, der kombinerer normativ og eksperimentel-filosofisk analyse. Først uddyber afhandlingen den retfærdighedsbaserede diskussion om den moralsk relevante kvalitet af personlig ansvarlighed, når fordelingsretfærdighed (inden for sundhedsvæsenet) vurderes, og standardiserer den ofte anvendte, men aldrig uddybede diskrimineringskritik mod held egalitarisme, som er den ansvarlighedsfølsomme teori om fordelingsretfærdighed. Med udgangspunkt i dette introducerer afhandlingen en ny række deontologiske argumenter til støtte for en ansvarlighedsorienteret fordeling af sundhedsressourcer mod den respektbaserede familie af kritikpunkter, nemlig kritikken af hårdhed, indgriben og diskrimination. Den genindfører ansvarlighedsorienteret fordeling af sundhedsressourcer som en fremmer af (selv)respekt snarere end en underminering af denne ved at argumentere for, at den differentierede behandling af de uforsigtige blot er en bivirkning af en moralsk tilladelig handling i vores bestræbelser på at skabe noget godt, og at vi har en uundgåelig pligt over for os selv og andre til at bevare vores sundhed.

Desuden undersøger afhandlingen i mere anvendte termer, hvordan specifikke typer af ansvarssensitive sundhedspolitikker, nemlig den konventionelle bagudrettede type (RSHP'er) og deres specifikation bygget op omkring ideen om gyldne muligheder (GO'er), klarer sig i forhold til banebrydende

definitioner af direkte og skadelig diskrimination. Ved at påberåbe sig et potentielt formildende argument baseret på begrebet ansvar for defensiv skade argumenteres der yderligere for, at selvom begge typer politikker overholder de nævnte definitioner, formår den moderate type, dvs. GO'er, at undgå bekymringer om skadelig diskrimination og derfor forekommer berettiget. Endelig demonstreres det på baggrund af et etisk godkendt og forhåndsregistreret tværnationalt vignetteundersøgelses-eksperiment blandt et repræsentativt udsnit af britiske og danske respondenter, at opfattet uretmæssig diskrimination er ansvarssensitiv, i det mindste i forbindelse med sundheds- og velfærdsydelser. Med andre ord konstateres det, at tilstedeværelsen af ansvar for det målrettede træk i betydelig grad bestemmer, hvilke tilfælde af forskelsbehandling folk klassificerer som uretmæssig diskrimination. Jo mere ansvarlig en person fremstilles for at være for det pågældende træk, jo mindre moralsk forkasteligt opfattes forskelsbehandling på dette grundlag at være på tværs af flere forhold, såsom ens oprindelsesland, kultur, type af det undersøgte område og endda personlige overvejelser vedrørende ens sandsynlighed for at opleve et lignende behov som personen i vignetten.

Samlet set bidrager denne afhandling væsentligt til vores forståelse af de moralske og empiriske dimensioner af personlig ansvarlighed i vurderinger af (uretmæssig) diskrimination. Den udgør dog ikke en konklusion, men etablerer et fundament, som yderligere forskning kan bygge videre på, uddybe, udfordre og udvide de indsigter, der er udviklet her.

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