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Linköping University Post Print

N.B.: When citing this work, cite the original article.

Original Publication:

Werner Schirmer and Dimitris Michailakis, The latent function of responsibility for ones health in Swedish healthcare priority-setting, 2012, Health Sociology Review, (21), 1, 36-46.

<http://dx.doi.org/>

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Postprint available at: Linköping University Electronic Press

<http://urn.kb.se/resolve?urn=urn:nbn:se:liu:diva-77544>

The latent function of 'responsibility for one's health' in Swedish healthcare priority-setting

(latest and slightly edited version published in *Health Sociology Review* 21(1): 36-46)

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Keywords: latent function; Luhmann; healthcare prioritization; responsibility; sociology; welfare-state

Introduction

In light of the vast medical evidence on correlations between unhealthy lifestyles (e.g. poor nutrition, lack of physical motion, and smoking) and the occurrence of certain diseases, the questions of whether people should be held responsible for their health conditions and, whether risk-takers should be given lower priority in rationing of scarce public resources have become the topic of critical debates in academia (for an overview Minkler 1999). The notion of individual responsibility for one's health has, for example, been described as an ideology of "blaming the victim" (Crawford 1977) and as a power instrument of the political economy (Donahue and McGuire 1995). Foremost, individual responsibility for one's health is discussed in medical ethics as a matter of fairness. From the viewpoint of liberal egalitarian justice, it seems fair to apply a principle of individual responsibility as means for priority-setting (Buyx 2005; Cappelen and Norheim 2006). Other ethicists such as Daniel Wikler (1987, 2002) dismiss the responsibility principle, not least because the extent of choice people

actually have is difficult to measure, but also because lifestyles are said to depend rather on environmental factors and class position than on free choice.

This article sees itself as contribution to the literature on individual responsibility, and more generally on healthcare prioritization, its aim is neither to ask whether the responsibility principle is fair or unfair; nor does it seek to motivate its moral grounds. Drawing on the systems-theoretical framework by the German sociologist Niklas Luhmann, we want to study how the responsibility principle functions as a communicative tool to justify Swedish healthcare priority-setting in a complex web of ethical principles. In this regard we want to contribute to a sociological understanding of the relation between the political system (welfare state) and healthcare.

We argue that the responsibility principle fulfils the latent function of protecting the self-description of the Swedish political system as a highly inclusive and caring welfare-state. Because prioritization implies ranking and exclusion it poses a threat for this self-description. As Luhmann's theory (Luhmann 1990a) suggests, the self-descriptions of political systems are inert and much less flexible than developments in their environment would require. Sooner or later, they can get in conflict with their environment and, thereby, create problems for policy-making. Assuming that a system cannot directly change its environment, there are only two realistic ways for the system to deal with contradictions between its self-description and the new environmental conditions. Either the system changes its self-description or it uses semantic tricks to blur the contradictions. This is the necessary context for understanding the function of the responsibility principle in Swedish priority-setting.

As our argument is rather complex, we first need to provide background information on the situation in Sweden. Like many Western countries, the Swedish healthcare system experiences severe budget problems. From the early 1990s the Swedish state began to consider prioritization in healthcare as an inevitable measure. Governmental reports from 1993 (SOU 1993) and, slightly modified, 1995 (SOU 1995) proposed an '*Ethical Platform*'

which contains three principles for prioritization. The first principle is the 'human dignity principle' which states that everyone has an 'equal worth and the same right no matter of personal properties and functions in society' (Socialstyrelsen).¹ It is accompanied by the 'need and solidarity principle' which shall ensure that resources be distributed according to medical need and urgency. The third principle is called 'cost-effectiveness principle' and expresses that an 'appropriate relation between costs and effects' should be aspired (see Socialstyrelsen). The principles are intended to be followed in a hierarchical order due to which cost aspects only play a subordinate role compared to aspects of dignity and need.

In 1997, the parliament finally followed the suggestion of the reports and passed the Ethical Platform (EP) in a Government bill (The Swedish Government 1996) as official guideline for prioritization. A few years later, however, the National Audit Office [Riksrevisionen] found that the EP in its current form failed with both its aims to provide decision-makers with guidance and to save significant amounts of money (Riksrevisionen 2004). As a consequence, the National Centre for Priority Setting [Prioriteringscentrum] was commissioned by the government to propose revisions and improvements of the EP. Prioriteringscentrum published its report in 2007 (Prioriteringscentrum 2008)² and suggested major changes. Amongst others, the platform should be expanded with a principle of *individual responsibility for one's health* according to which people can be given lower priority if their lifestyle threatens their health or the effect of the provided medical treatment.

Against that background our argument presents itself as follows: The responsibility principle contributes to the solution of a problem generated by the Ethical Platform. Counter to its official purpose (i.e. manifest function), the EP is a solution to a latent problem of the Swedish welfare-state: As prioritization implies selection and exclusion, it is a threat to the Swedish self-description of being an inclusive welfare-state. The EP obscures this contradiction between the self-description (inclusion) and prioritization (exclusion) and, thereby, protects the integrity of the self-description. However, the EP's design proved to be

dysfunctional for its official purpose of providing guidelines for priority-setting. As a reaction, the report from 2007 addresses the manifest problem in a more effective way while at the same time providing a functional equivalent for the EP's latent problem. The responsibility principle plays a crucial role for this endeavour as it changes the meaning of the human dignity principle from unconditional to conditional inclusion. Human dignity means then no longer only equal human worth for everyone but also respect for one's integrity as a capable agent who has to take responsibility for his/her actions. The article ends with concluding remarks.

Methodological background

Often the functional method is (falsely) identified with the social theory called functionalism, e.g. in its Parsonian and Mertonian variants. Critics then reject the harmonistic or teleological conceptualisations of society and social relations as well as their emphasis on societal needs, system survival, equilibrium, or the maintenance of the normative order (see Sanderson 2001). The functional method has also been criticized for its failure to provide sound explanations (see classically Dore 1961; Hempel 1959). In its Luhmannian version (Luhmann 1995: 52-58), the functional analysis 'has nothing to do with earlier varieties of structural or causal functionalism', as Lee & Brosziewski note (2009: 213). For Luhmann, functionalism is no 'hypothetical-deductive system' (Luhmann 2005 [1962]: 26) but a 'heuristic method' (Luhmann 1979: 5) that can be used to describe its object in terms of problems and solutions. We call a *function the solution of a problem*. To illustrate this with an example, the question 'What is the function of prioritization?' is not the same as 'Why does prioritization exist/take place?' or 'What are the causes of prioritization?' From a certain system's perspective, prioritization can be considered as a functional solution to the problem of lack of funds. However, the existence of prioritization is not *explained* by lack of funds. This is beyond the aim of the functional method. Rather, it 'seeks abstract but specific, precisely to define

reference-problems, from which they can treat different things as similar, as functionally equivalent' (Luhmann 2005 [1964]: 45). Instead of prioritization, the problem of insufficient funds could be approached with functionally equivalent solutions, for instance tax-raise or mandatory private supplementary insurances. The added value of this method, then, is to find functionally equivalent ways of managing lack of resources in healthcare.

The systems-theoretical version of the functional method is not only interested in the way a problem is solved but also looks in the opposite direction, i.e. it asks to which reference-problem the observed phenomenon is a solution (see Knudsen 2010: 9). Sometimes, the reference-problem has to be identified by the researcher because it is *latent*: not addressed in official descriptions, not necessarily recognized by the involved actors or even covered up (see Schneider 2005: 59).³

Solutions are solutions only in reference to problems and problems are only problems for specific observing systems. The reference-problems *do not explain* the occurrence of their solutions. Problems and solutions can be parts of a chain of preceding and subsequent problems and solutions. The solution to one problem can itself be/create a subsequent problem that, in return, requires a subsequent solution. In this article, we argue that both the Ethical Platform, and *in extensio*, the responsibility principle, provide solutions to a problem that has to remain latent.

The latent function of the Ethical Platform

The official purpose of the Ethical Platform and its three building blocks human dignity principle, need- and solidarity principle and cost-effectiveness principle is to 'steer all prioritizations that are made in healthcare' (Socialstyrelsen). However, investigations showed that the EP has fallen short of its task to provide guidelines for prioritization and is, therefore, considered a failure. Contrasting the official descriptions, we argue that the EP is a successful solution but its reference-problem is another than the one recognized by its proponents and

critics. We contend that the EP *fulfils a latent function* exactly with its appearance and content. In order to understand this latent function, we have to address the following questions:

- Who is in charge of solving the problem of prioritization?
- To which latent reference-problem is the Ethical Platform a solution?
- How does the Ethical Platform solve this problem?

Whose problem?

Underfinanced healthcare services create problems for many social systems and groups. Patients as well as doctors and administrators are groups who directly or indirectly suffer from lack of funds in healthcare. Possible causes cover issues such as demographic aging, rising costs for treatments and medication, recession in the global economic system and more. Whereas these singular factors come from different societal realms, Luhmannian systems-theory gives a clear answer to the question of which social system is in charge of the problems. It is the function of the system of *politics* to 'provide collectively binding decisions' (Luhmann 2000: 84). This formula refers to decisions by governmental authorities that are supposed to be binding for citizens (e.g. legislation). However, it is not the component of decisions, and its power-based organizational infrastructure that is of interest here but the aspect of 'collectivity' (Nassehi 2002). Politics addresses a collectivity, generally referred to as the 'citizens', the 'people', or the 'public', and is, in return, legitimated by this collectivity. In this regard, Nassehi sees an important part of the function of politics in the 'production of societal visibility and accountability' (Nassehi 2002: 45). In its modern form as welfare-state, the political system is held accountable for the well-being of its citizens and for the provision of collective goods such as security, technical infrastructure, education, and not least, healthcare. Although executed by specialist professions and organizations (military and police; technicians and craftsmen; schools; hospitals), the expectations and claims are directed

toward the central organizations of the political system (Schirmer & Hadamek 2007). This is especially true in Sweden which has a strong tradition of an all-encompassing welfare system, and where the by far biggest share of healthcare expenses is financed by the state with tax money. Prioritization among medical treatments and patients, hence, is a core theme for welfare-state politics. Accordingly, it was the Ministry of Health and Social Affairs that appointed the investigation on how to conduct prioritization. The explicit purpose of the investigation was to achieve the legal foundations for prioritization and the Ethical Platform was the result.

The latent reference-problem

Sweden is one of the economically and socially most advanced countries of the world. According to the World Values Survey, it scores very high on secular-rational values and on self-expression: gender equality, tolerance for diversity, and environmental protection play an important role in politics and public life (Inglehart and Welzel 2005: 87, 124). Formally, Sweden is a constitutional monarchy with parliamentary democracy; it was ruled by social-democrats-lead governments for many decades. Like other Scandinavian countries, it has fostered a very extensive and inclusive welfare regime of social-democratic kind (Esping Andersen 1990). The most central values of the Swedish welfare state are *equal human worth* and *equality*. 'Alla ska med' (literally 'everyone onboard') can be regarded as the guiding formula of the all-encompassing welfare-state. It means that everybody should have access to welfare services; nobody should be excluded from social benefits regardless of income, age, gender, ethnicity or place of residence. This formula is deeply anchored in the Swedish political system's self-description as an inclusive and extensive welfare-state. Its acknowledgment is vital for any political success in Sweden, as could be observed in campaigns for the national elections of 2006 where the leading political parties from both the conservative and socialist camps (Conservatives and Social Democrats), each utilized 'alla ska

med' as a motto for their own political programs.⁴ The international reputation and the high expectations from the citizens make it necessary for any Swedish government to foster, maintain and protect the self-description of the welfare-state.

The solidarity-based, tax-financed health system ensures that taxpayers contribute to the costs dependent on their income while they (should) have the same rights and chances to receive healthcare *independent* from their economic spending power. However, rising costs for healthcare set pressure to reduce expenses significantly. While rationing and prioritization have been pinpointed to be logistic answers to the lack of funding, they trigger enormous problems for the integrity and credibility of the self-description. Prioritization means per definition selecting someone instead of someone else. It is about giving treatment and care to some while not (or to a lesser extent) to others. Thus, prioritization conflicts with the formula 'alla ska med' because not everybody who needs to can be on board at the same time.⁵

It is exactly here where we find the latent reference-problem of the Ethical Platform: the structural conflict between the budgetary necessity of prioritization in healthcare and the political necessity of protecting the self-description of the welfare-state. This conflict could only be solved by either raising more funds or by adjusting the self-description towards less inclusivity and less services. Since the latter has recently not been an option, the function of the EP is to *invisibilize* the structural conflict and to protect the integrity of the self-description of the inclusive welfare-state despite the (partial) exclusion by means of prioritization.

How does the Ethical Platform solve its reference-problem?

The platform uses a few semantic tricks to fulfil its task.

- a) The human dignity principle (HDP) is set on the first position and declared unconditional while the selection aspect as a means of 'prioritization' is downplayed.

- b) The label 'ethical' simulates a fictional unified perspective across structural societal differentiation (especially medicine and economy), thereby disguising the role of politics.

a) The role of the human dignity principle

The first public investigation from 1993 which provided the vastly unchanged basis for the platform describes the human dignity principle as follows:

According to the human dignity principle, the individual human being has a unique worth and every human being has the same worth. Human dignity is not linked to individuals' personal characteristics or functions in society such as capabilities, social status, income, state of health etc. but to the very existence.

(SOU 1993: 95)

Drawing on the same value system as the UN Declaration of Human Rights, this idea of 'equal worth' refers to something intrinsic and not something determined socially. In the same paragraph (not contained in the excerpt), the report adds that 'nobody is more prominent than anybody else'. Human dignity is seen unconditional and absolute as it implies 'that one always and under all circumstances consider and treat the human being in terms of what she is and not in terms of what she has or does' (The Swedish Government 1996: 9).

When, however, equal worth is ascribed to everyone due to their human nature (born as equals), rankings and exclusions on this basis become difficult. Whereas the reference-problem of prioritization is how to *exclude some people*, the HDP's contribution is to support the claim to *include* everybody. Selecting some at the cost of others *does not take place because of but only despite* equal human worth (Schirmer & Michailakis 2011: 270). The HDP basically contradicts the very idea of prioritization (see figure 1). Therefore, the HDP cannot give guidelines for how to make priorities, but only for how *not to*. The idea of equal worth, then, can only serve as a barrier to any type of illegitimate (unethical) discrimination.

Figure 1: contradiction

In terms of decision-making, the HDP obviously does not seem to be a great help. Yet, for the latent function of the Ethical Platform, it plays an important role as its emphasis on equal worth and antidiscrimination strongly supports the self-description of the inclusive welfare-state. Because the HDP is placed on the first and overarching position of the platform, any legitimate prioritization decision can be framed as meeting the criteria of 'human dignity' and 'equal human worth'.

At the same time, the EP and its accompanying documents protect the self-description of the welfare-state by downplaying both the HDP's limitations as a criterion for prioritization and the meaning of prioritization as a means to rank, select and in certain cases even exclude people of equal worth. Descriptions of the EP and its principles utilize a communicative trick to achieve this, as a short text passage from the investigation from 1993 can illustrate. The excerpt is taken from the section where the three principles are presented:

The human dignity principle is a necessary but not sufficient ground for prioritizations in healthcare. If everyone has the same worth and the same right but resources are not unlimited, not everyone can get what they actually have the right to. The *dilemma is then* to choose those who should get what they have a right to without getting into conflict with the human dignity principle. Therefore, the report wants to suggest the need- or solidarity principle as additional principle for priority-setting.

(SOU 1993: 95, our emphasis)

On the one hand, this text passage considers the HDP as a principle for prioritization and it also stresses its imperative. On the other hand, the excerpt admits the HDP's insufficiency to direct priorities in the case of scarce resources. While scarcity is introduced as a merely conditional constraint for the practicality of the HDP, the text embezzles the fact that

prioritization is necessary just because there *is* scarcity in the first place. The underlying logic applied here seems as follows: If resources are not scarce, the HDP is an important criterion for prioritization. If, by contrast, resources *are* scarce, the HDP with its claim to equal worth and equal rights needs to be complemented by another (set of) principle(s) but whatever these criteria are, they are hierarchically inferior toward the HDP. Inclusion is the political aspiration while exclusion is the economic necessity. What is here presented as the dilemma of whom to select corresponds to the very idea of prioritization and exists independently from the HDP and its implications. With help of the communicative trick applied in the excerpt, not only the general impracticality of the HDP can remain under the surface. Even more important is the fact that the very meaning of prioritization is hollowed out by basing it on an overarching principle that makes selections actually impossible. But the self-description of the welfare-state can remain intact because prioritization and 'alla ska med', operationalized via the HDP, does not longer look like a contradiction (see figure 2).

Figure 2: solution from 1993/1995

b) Unified ethical perspective

Despite its claim to be of general relevance for all actors involved in prioritization in healthcare, the EP is a *political* document. Typically for political documents, it uses a description of society that assumes a collective of human beings who share values, norms, culture or anything else that makes them form a community. At the top of this community are normally the political system and its governmental organizations. In this case, however, the EP puts *ethics* at the centre, while at the same time disguising the special role of politics. By

labelling the platform itself and its principles 'ethical,' a fictional unified perspective across structural societal differentiation is simulated.

According to Luhmann, modern society is differentiated into functional subsystems, such as economy, politics, medicine, law, etc. Each of them observes with its very own binary code (such as payment/no payment, government/opposition, ill/healthy, legal/illegal). Function systems reduce the enormous complexity in the world to a small extract of relevant social reality. They can only see what their unique observation perspective allows them to see. For everything else, they are blind and indifferent. The system of economy, for instance, can only observe the costs of a medical treatment but not assess its medical value; the system of medicine can evaluate the success of the treatment but is blind for the financial resources it eats up. At the same time, none of the systems can claim exclusivity on social phenomena, such as the medical treatment from the example. That can occur as a medical, an economic, a political, and a legal, etc. event with different, system-specific implications. Any social event in modern society has a plurality of socially relevant meanings, depending on the context and the function system-specific perspective it is observed with. Due to this plurality of systems and their perspectives, modern society itself is nothing more but the unity of the difference of incongruent observation perspectives of the function systems, it is 'a polycentric, polycontextural society' (Luhmann 1997: 75). Its structure rules out the possibility of a 'central and therefore "objective" point of view' (Luhmann 1997: 75).

A practical consequence of this differentiation is the fact that prioritizations are made on many different organizational levels (national, regional, communal governments; hospitals and surgeries) and by different professional roles (politicians, administrators, economists, hospital managers, doctors, etc.). Not only do they deal with different aspects; they also follow their own rationalities as required in their functional and/or institutional contexts within which they operate: the economical rationality of reducing costs, the political rationality of steering and surveying resource administration, the medical rationality of

providing the best and most suitable treatment for the patients in relation to their prospects to be cured.

Structurally, ethics cannot bridge the gaps of differentiation. Ethics provides (only) a vantage point among many, which is neither better nor more justified nor more insightful than the ones from the function systems. If something is observed in terms of ethics, it appears as 'ethical' or 'unethical', but nothing is said about values that only play a role within certain function systems. As Luhmann states, the function systems operate 'on a level of higher amorality' (Luhmann 1990b: 24), shielded from ethical restrictions. For example, court decisions have to be based on laws and evidence, not on moral reasoning. Important for scientific research is the truthfulness of hypotheses, not the moral discomforts they create. The economic value of an investment is measured by the profit (or loss) it generates, not by its potential moral downside. Political interests can (and sometimes have to) be pursued without caring about morality.

Correspondingly, the Ethical Platform should not be expected to provide a de-differentiation of perspectives and rationalities, as this is structurally impossible. Instead, the achievement of the EP lies just in the communicative *obscuration* of these social-structural differences. Even the cores of the principles of the EP refer to political, medical and economic circumstances, but by framing them 'ethical', the EP can be presented *as if* it addresses a higher goal that transcends the incompatibilities of system-rationalities. According to the EP, it then becomes a matter of *ethics* (and not primarily of economy) to avoid expensive treatments when cheaper ones are available. It becomes a matter of *ethics* (and not primarily medicine) if patients with higher urgency are prioritized, and finally, it becomes a matter of *ethics* (and not of politics) when people have to show to other competitors for the scarce resources if they are not given priority. In this regard, the ethical perspective claims the semantic primacy over the perspectives of function systems. The label 'ethical' simulates a common moral denominator between the involved parties that deflects from the political

inducement behind the form of the EP of protecting the self-description of the welfare-state. As prioritization becomes an ethical issue, accountabilities are shared, and politicians appear as no more responsible for its success than are administrators and doctors.

The function of the responsibility principle

If, as suggested here, its (latent) function lies in the protection of the welfare-state's self-description, one can consider the Ethical Platform a success. While the current design with the inclusive HDP on top and the excluding principles in a subsidiary position is functional for the latent purposes, this benefit is bought at the price of low applicability for decision-making. The reason for this is that the paradoxical relation between inclusion and prioritization (as exclusion) is not resolved; it is only hidden, and made operational by setting the focus on the inclusive aspects (equal human worth) while downplaying the discriminatory feature of prioritization. After critics from practitioners became too many, the Ministry of Health and Social Affairs could no longer ignore the limited usability of the EP and had to figure out improvements which, as a consequence, might also affect its capability to solve the latent problem. It is against this background that Prioriteringscentrum was commissioned to conduct the investigation and make suggestions for changes. The *reference-problem* of the report is then to reform the EP in a way that enables decision-making to accommodate the no longer ignorable expectations while at the same time not harming the self-description of the welfare-state.

The most important innovations concern a change of content of the human dignity principle and the introduction of the responsibility principle as a fourth principle. Both are closely connected in their design. In accordance with the investigations from 1993/1995, the report from 2007 interprets the semantic core of human dignity, i.e. 'equal human worth' as people's 'same right' to medical care. However, the report suggests a shift from an unconditional ethical imperative to a conditional – and therefore negotiable – legal approach

of rights and obligations. The HDP should then express two different rights, addressed through an *operational principle* and a *general attitude towards people* (Prioriteringscentrum 2008: 118).

The operational principle focuses on 'an equal right to the necessities for living a good life' (Prioriteringscentrum 2008: 119) and aims at the inclusive aspects as already established in the EP from 1995. The general attitude states in its basic formulation that the 'human dignity principle implies equal rights for respect concerning one's dignity' (Prioriteringscentrum 2008: 119). What at first sight sounds like a paraphrase of the operational principle gets its specific meaning through the operationalization of *respect*:

We should show respect for people's integrity. Hence, from the outset we should consider people to be capable agents who can take responsibility for their own actions.
(Prioriteringscentrum 2008: 119)

Greater influence also carries greater responsibility. Respect for an individual's dignity requires both respect for the individual's right to decide over their own life (autonomy principle) and assignment of responsibility based on individual prerequisites.
(Prioriteringscentrum 2008: 142f)

The report uses the figure of respect in order to connect human dignity with responsibility. Respect means to treat people as agents who can take care of themselves (Schirmer, Weidenstedt & Reich 2012), but for the report, this attributed agency also has the implication of being held responsible for the consequences of one's actions. It is, then, only consequent to suggest the introduction of a responsibility principle on the same 'ethical' level as medical needs, solidarity and cost-effectiveness. The following text passages show how the report describes the principle:

Responsibility for one's health involves an obligation to preserve or improve one's health. The obligation can be met by preventing ill health. It can involve, e.g., choosing a healthy lifestyle or avoiding unnecessary health risks.
(Prioriteringscentrum 2008: 147)

In a resource distribution context, the responsibility principle means that needs arising from neglecting one's responsibilities can be given lower priority in relation to other needs when resources are scarce.

(Prioriteringscentrum 2008: IV)

The semantic achievement of the responsibility principle (RP) is to bring together the concepts 'healthy lifestyle' and 'responsibility for one's health' (see Schirmer and Michailakis 2010: 275-276). On the one hand, it draws on scientifically established causal relations between certain lifestyles and the likelihood of illness. The effects of lifestyles on illness can be measured and verified by data, and can therefore be treated as *objective facts*. On the other hand, the RP draws on the idea that the causal chain of events (lifestyle → health outcome) is mediated by intentional actions of an individual, as the word 'unnecessary' implies. The health outcome can be attributed as a *decision* to omit counter-measures for avoiding the illness (see Meyer and Jepperson 2000: 113). The RP is, then, only the specific mirror of the more general HDP:

The responsibility principle means that we should respect people by making them responsible for their actions and responsible for the consequences of their actions based on individual prerequisites.

[...]

[This] is a consequence of the human dignity principle as formulated. This principle asserts that we should respect people by considering them to be free and capable individuals who can take responsibility for their own, and to some extent for other's, life and the consequences of their actions, with consideration to individual prerequisites.

(Prioriteringscentrum 2008: 142)

As this text passage shows, the HDP is defined in terms of responsibility and the RP in terms of dignity. This is neither a redundancy nor a mistake as each makes its own contribution. Like in the original Ethical Platform, the latent means of the HDP is the protection of the self-description of the inclusive welfare-state. After the reformulation and re-interpretation, the HDP still stands for inclusion (the same rights for everyone) via the 'operational principle'. With its emphasis on respect for one's dignity, even the general approach *looks like* inclusion. Everybody has the right to receive respect, to have his/her personal integrity defended and not

to be victimized. However, the connection to the RP makes sure that this inclusion is only *conditional* because now the rights come in a bundle-package with duties. If these duties are neglected, so the underlying logic, the general right to inclusion can turn into factual exclusion. This exclusion is self-inflicted as it is a consequence of the agency people are ascribed by being respected.

Both HDP and RP gain through their mutual constitution. The RP receives its ethical status through the HDP whereas the HDP gets the ability to support exclusion through the RP. Hence, there is no longer a conflict between the HDP and prioritization. Whereas this conflict had to be obscured in the Ethical Platform, the new solution enables prioritization to take place without contradicting its literal meaning.⁶ Exclusions are now not only possible; they can even be executed in the name of ethics without negatively affecting the self-description of the welfare-state. On the contrary, the welfare-state can now claim that it respects its citizens and offers inclusion for everybody, thereby satisfying the needs of the inclusion-formula 'Alla ska med'. It is the people themselves who (intentionally or not) account for their exclusion or lower priority (see figure 3).

Figure 3: solution from 2007

While suggesting the incorporation of the RP into the Ethical Platform, Prioriteringscentrum's report admits similar problems with its application in concrete decision-making situations as

have been pointed out in the international debate (compare with Minkler 1999; Wikler 1987, 2002):

The causal association between a person's behaviour and state of health must be sufficiently clear. It is about the possibility and reasonability of assigning a person responsibility for his/her illness. Responsibility implies causality, and it is notoriously difficult to establish a causal association with sufficient accuracy between, e.g., behaviour and ill health.

(Prioriteringscentrum 2008: 149)

[I]t is important to point out that applying this principle requires several strict conditions to be fulfilled (e.g., a clearly causal relationship between behaviour and state of health). Except in certain, clearly defined situations, the principle would be seldom applied in practice.

(Prioriteringscentrum 2008: 166)

These limitations underscore our suspicion that the RP is actually not designed as a means for decision-making but has first and foremost the symbolic function of supporting the new meaning of the HDP. The notion of individual responsibility becomes a strong message towards potential receivers of care to acquit themselves in the name of ethics. It reflects a *quid pro quo* rationality that emphasizes the duties accompanying the rights provided by the welfare state. Despite its limited applicability in concrete decision-making (just as the HDP in its previous and new version), the RP plays a crucial role for the political necessity to save money. In some few clear cases people might actually be given lower priority, but more important is the communication of the new expectation that should trigger people to change their lifestyles towards more healthy nutrition, more motion, less dependence causing substances (tobacco, alcohol, drugs), and less hazardous behaviour (like extreme sports).

Conclusion

The article provides a functionalist interpretation of the notion of 'responsibility for one's health' for prioritization politics in Swedish healthcare. When combined with the Luhmannian systems-theory, the functional method is a powerful tool to uncover latent problem-solution

relationships. Unlike other work on individual responsibility in priority setting, the objective of this article is not ethical but sociological (Luhmann 1990b: 37), namely to understand the responsibility principle in a context of system-specific latent problems and solutions for the political system and its self-description. The reality of political self-descriptions can differ strongly from the perceived reality of medical and administrative practice (Kieserling 2004). From the viewpoint of decision-making doctors, the Ethical Platform appears rather as a generator of problems. Luhmann's theoretical framework, however, allowed us to maintain critical distance from these surface descriptions and instead find a latent function of the Ethical Platform; we see it as a political device to solve a problem for the political system's credibility as a welfare-state. The underlying abstract logic which we demonstrated in the case of Sweden might be similar in other countries. Self-descriptions of Anglo-Saxon welfare states are certainly different from Scandinavian ones but they also need to be protected against contradictions with the environment. It is the task of future research to show which communicative measures might be needed in which case.

For the case of Sweden, we have argued that the latent function of the Ethical Platform is – against (or despite) its official purpose of guiding prioritization in healthcare – to protect the credibility and integrity of the self-description against the necessity of prioritization, however at the cost of being unable to justifying priorities. The *latent function of the responsibility principle* is, in a revised ethical platform, to unite equal human dignity with one's integrity as a capable agent. As agency implies responsibility, illness can be considered as self-inflicted in many situations. The contradiction between the inclusive self-description of the welfare-state and the exclusive character of prioritization is suspended.

Up to now, the reformulation of the existing ethical platform as proposed by Prioriteringscentrum has not lead to an officially adopted new ethical platform yet. The responsibility principle is still contested in debates, but at the same time, it becomes more and more acceptable to expect from people to conduct a healthy lifestyle (Michailakis and

Schirmer 2010). As the responsibility principle is not (yet) acknowledged on legal grounds as a new basis for priority-setting, physicians have to justify decisions referring to lifestyle with purely medical reasons (e.g. smoking severely endangers the effect of treatment X, and therefore, non-smokers get priority).

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Notes

1 This and the following translations from Swedish and German are our own.

2 References are taken from the English version which was published in 2008.

3 According to the Luhmannian framework, functional relations are always constructions made by observers. When we observe latent reference problems and latent functions, we cannot exclude the possibility that other observers using different perspectives would construct different problem-solution-chains as we do here. We thank one of the anonymous reviewers for pointing this out.

4 When in the last election the conservative party won, it did so – according to commentators – just exactly because it addressed genuinely social democratic issues and solutions.

5 While priority-setting takes places on many levels (e.g. between different healthcare realms, diseases, treatments), most of the principles of the ethical platform refer to the individual (human dignity, need, solidarity). The responsibility principle refers more or less directly to the individual because it is the individual who is held (or not held) responsible for health outcome. In the end it always comes down to the individual whose illness/injury is prioritized before others. And this also means, that some people will not get treatment, and in this regard, excluded from care.

6 Prioriteringscentrum makes no doubt about this meaning: To prioritise means to place in rank order and choose ' (Prioriteringscentrum 2008: 19).