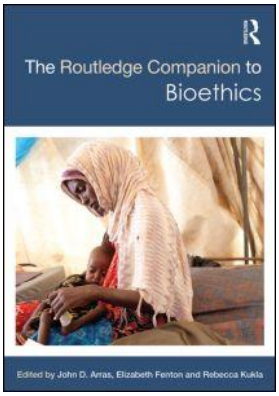

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Incentives In Health

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INCENTIVES IN HEALTH
Ethical Considerations

Richard Ashcroft

Introduction

The use of incentives is an increasingly popular technique in health promotion (Oliver and Brown 2012). The central idea is this. A person currently has a pattern of behavior which has an impact on their current or future health. Although adopting a different "health behavior" would improve their current or future health, they are unwilling or unable to do so. Other methods of changing this behavior (typically, advice and information-giving, or personal resolution-making) may have been tried but without any, or without consistent, success. The behavior itself may involve no direct harm to others, so that direct coercion may not be permissible. The behavior is sufficiently under the voluntary control of the person that a "hard paternalist" justification for forcibly changing the person's behavior for their own sake (as opposed to for the prevention of harm to others) is also lacking. Under these circumstances, an incentive may be offered to the person, in the hope that their desire for the incentive is sufficiently strong that they will change their behavior in order to earn the incentive. And further, having changed their behavior, and earned the incentive, their behavior will now not revert to the previous, undesirable behavioral pattern. Although this account of incentives gives a good indication of why incentives in health behavior change may be a good idea, there are some frequently identified moral problems which may afflict incentive schemes, at least sometimes. They may be coercive (the idea of "the offer you cannot refuse"); they may be corrupting (if people are induced by the offer of an incentive to act against their own principles or to seek to be paid where they should act from duty); they may be unfair (if some people are "rewarded" for a change in behavior but others are not, or if certain kinds of people are unfairly singled out for intervention where others are left alone).

Examples

This sketch is rather schematic, so here are some examples of practical incentives in healthcare. The standard case is smoking cessation. If I am a smoker, while there are a variety of reasons to limit my smoking where it imposes harm on others, few would argue that I should be prevented from smoking altogether, if I wish to smoke. But there is a weak public interest in encouraging me to give up smoking (because of the long-term costs my smoking imposes on the health system), and a soft paternalist reason to

discourage me from smoking for my own sake (I may be irrationally discounting the future harms to my own health or simply unaware of them). Absent a notion that we have a duty to the commonweal to be as healthy as possible, these public good and soft paternalist reasons may warrant no more than informing and seeking to persuade me of the hazards of smoking and the benefits of quitting. However, most confirmed, habitual smokers do want to give up smoking. They fail to do so for many reasons, ranging from addiction, to social reinforcers that make smoking attractive (peer pressure, for instance), to the pains of withdrawal. In particular, while the health benefits of not smoking extend over one's whole lifetime, these are in an important way non-experiential. Being healthy is, for the most part, a state of *not* feeling ill. Illness has a rich phenomenology of pain, discomfort, impairment, and so on; whereas health only intermittently expresses itself as felt wellbeing and then usually only in contrast to recalled or anticipated illness or discomfort. The pains of quitting smoking are real, however, and are experienced directly; and so is the sense of desire and frustration which go along with wanting to smoke and trying not to give into that want. These pains and wants continue for quite a long time. Informally, smoking cessation experts say that it takes up to a year of confirmed non-smoking for a once-habitual smoker to become unlikely to start again.

A number of health promotion schemes have experimented with the use of incentives to help people quit smoking. Usually these are restricted to people who have already consulted smoking cessation services and have tried and failed to give up smoking for more than a few weeks. The incentive scheme usually works by offering small money payments at staged intervals over six to twelve months, with a relatively large completion incentive if the participant successfully quits smoking for the whole course of the scheme. Some schemes rely on self-reported non-smoking, but others use physiological tests to check whether the participant has smoked in the recent past. The total sums participants stand to gain are usually no more than a few hundred dollars, and it should be noted that these are usually much less than the money they will have saved by not purchasing tobacco products over the time they are participating in the scheme (Volpp et al. 2009).

The smoking cessation case is an example of an incentive offered to someone who wants to stop doing something, finds it hard to do so, and is seeking help. A different kind of incentive scheme is represented by an intervention tried in the UK to encourage teenage girls to undergo human papilloma virus (HPV) vaccination. In this case participants were offered a low-value shopping voucher, with receipt contingent on completing the vaccination schedule. HPV vaccination involves presenting on three occasions a few days apart to receive an injection of a vaccine, which is considered to be safe and effective in preventing HPV infections, which have been associated with an increased lifetime risk of cervical cancer. Because HPV is often transmitted sexually, it is thought that vaccinating teenagers before they become sexually active will confer the greatest benefit in terms of reducing their risk of infection. The nature of the vaccination is such that teenagers will typically be competent to consent to the vaccination, but being teenagers may be relatively risk prone, less likely than an adult to give thought to their lifetime health and the long-term consequences of their decisions, and so less than ideally likely to participate in a vaccination scheme merely because it is a good idea. Thus, participation rates will be lower than public health professionals would like, both in terms of individual protection and in terms of "herd immunity." As with smoking, the benefits of vaccination are remote in time; unlike smoking, the harm and

discomfort associated with the intervention is rather small; and unlike smoking, to be successful the participant only needs to do something three times rather than adopt a whole new lifestyle. An incentive scheme like this one seeks to promote uptake of a beneficial service rather than long-term behavioral change (Mantzari et al. 2012).

Incentives can take many and various forms, and the debates can quickly become quite confusing. The type I have discussed in these two examples involves making small, definite positive payments to people to do something that is in their own interest, and is acknowledged by participants as being in their own interest, as a way of overcoming barriers to achieving people's own goals which reflect neither their own preferences nor rational choice. However, incentives may take a negative form: In so-called "pre-commitment" contracts, for example, someone may place a sum of money in trust for a set period, and if they fail to adhere to a planned change of behavior, they will lose that money (Karlan and Appel 2011). Incentives can also be uncertain: Many schemes offer people a lottery ticket rather than a definite sum of money (a chance of winning $500 rather than a certainty of winning $5). Incentives are not always targeted at the service user or citizen personally—many schemes involve making conditional payments to professionals, who must meet some service uptake or usage or measurable outcome target. And incentives can be hard to distinguish from schemes such as "conditional cash transfer" schemes in education or social policy, which combine elements of behavior change and welfare benefits in ways which have been quite controversial in the debates around welfare reform (*Journal of Applied Philosophy* 2004). For the purposes of this chapter I will concentrate on incentives to individuals who are seeking to change their own behavior, for health-related reasons, where these incentives are offered in a healthcare setting, rather than via other types of public or private service setting. For practical purposes it makes sense to call these individuals "patients," even when they may be neither ill nor consulting a healthcare professional at the point when they encounter the incentive scheme. We will assume that the incentive scheme is focused on health, and that it is operated and supervised by health professionals, be those doctors, nurses, midwives, or public health professionals.

Autonomy and Incentives: Coercion

In introducing incentives, I described a space in between the free, deliberate, and more or less unmediated decision of the individual and the forced choices or behaviors under coercion or hard paternalism. Here the person is the author of their own behavior but that behavior is influenced by the offer of an incentive (or series of incentives in a structured scheme) by a second party. Many of the moral issues arising in the use of incentive schemes turn on the autonomy-related questions arising in this space.

One straightforward question is whether incentives are coercive. Most readers will be familiar with the idea of an "offer you can't refuse," which apparently confers some benefit on the recipient, but on very disadvantageous terms, and in a form and in a context where there is no alternative but to accept. An incentive has the form of an offer, which requires a choice by the recipient: If you act in a certain way, you will gain the incentive; if you don't, you will not; but it is up to you whether or not to act in this way. However, although the incentive has the form of an offer, some offers will be instances of exploitation, others will be straightforward threats dressed up as offers. Three responses to this question come immediately to mind. The first is to accept that some incentives, or some schemes, or some incentives offered to people in some particular situations, may

in fact be coercive. But unless we simply stipulate that coercion is always wrong, this simply redefines the problem as one of stating whether or not such incentives are unjustifiably coercive. It is the justification that will matter, rather than the coerciveness. The same applies to attempts to dismiss incentives as paternalistic: so they may be, but paternalism is sometimes justified. The second is to deny that incentives, when properly understood and properly formulated, are coercive in any reasonable sense of that term. The third is to hold that the claim that incentives are coercive is not so much wrong as misconceived.

The response that incentives are sometimes coercive, but that sometimes this coercion may be justified, is commonly mentioned, especially in media discussions of incentives (Parke et al. 2013; Promberger et al. 2011). As its features of interest depend on debates about justified coercion (and, relatedly, justified paternalism) that are outside the scope of this chapter, I set it aside (for a discussion of justified coercion, see Lamond 2001). The second response is more specific to incentives. Here the argument is that in its proper sense, an incentive must satisfy certain conditions if it is to be distinguished from a payment, a bribe, or an unfair inducement (much as we try to distinguish reasonable wages from tips, bribes and unfair exploitation). One element of an incentive is that it must be offered in a context where the recipient has an occurrent or potential desire to change their behavior in the direction signaled by the incentive, and that this desire is occurrent or potentially so in the absence of that incentive. Thus, the smoker must wish to give up smoking; the teenager would, other things being equal, wish to be vaccinated against HPV. The incentive should not be of a size or type, or offered in a context, such that it changes the desires of the recipient, or somehow overrides them, in a way which, absent the incentive, they would not endorse. If we accept this condition, then it is hard to see how an incentive could be coercive. What it may do is strengthen the determination to act on one's occurrent desire to quit smoking, or to consider one's preferences in such a way that one's potential desire to be vaccinated against HPV becomes occurrent. The HPV case is somewhat more difficult to defend than the smoking case, as the argument rests on a potential or all things considered desire in a set of circumstances where that desire is not occurrent or all things have not been considered (we are thinking of teenagers here!). It must be acknowledged that there is an element of paternalism here that will not go away, no matter how much we frame things in terms of autonomy and choice: We are only offering the incentive because, like the offer of HPV vaccination itself, we think it is a good thing, and it would be wise to take it up. Prior to the offer, the recipient may not have thought about HPV vaccination at all, or not have made up her (or, more recently as HPV vaccination has been opened to boys too, his) mind about it. But though the offer may have a paternalistic inspiration, the form of the offer, which permits refusal, and where the sums of money are small and refusable themselves should the individual actually prefer not to be vaccinated, is autonomy respecting. I do not propose to give a full set of necessary and sufficient conditions for an incentive to be non-coercive. The sketch of the argument is simply to show one illustrative way in which the characterization of incentives as coercive in form and essence may fail.

Turning to the third response to the coerciveness claim, the misconception argument, the main line of argument here is psychological. The thought is this: The argument from coercion sees the free and autonomous subject not doing something (being vaccinated) or doing something we think they should not (smoking); they do not respond to information, argument, or persuasion; so we offer an incentive, and lo! They change their

behavior. This must be evidence, prima facie, of force. First, to head off one natural skeptical challenge to this argument, responding to an incentive rather than to a (verbal) reason looks like economic behavior rather than health behavior. It looks as if I was just waiting to see how much you will pay me to quit smoking, rather than making a decision to quit smoking because it is a good idea for me to quit smoking. So if I am quitting smoking for that sort of reason, it must be because your offer of an incentive is crowding out my underlying preference to smoke. It can be assumed that this is "really" my preference, because, absent your incentive, I *actually* carry on smoking, notwithstanding my *saying* that I really don't want to smoke. And in this line of thought it is assumed that once you take the incentive away, my real preference (for smoking) will reassert itself. This again is evidence that while I was not smoking it was due to your coercion, because as soon as you stop forcing me not to smoke, I start smoking again. Furthermore, the skeptical challenge goes, this is also evidence that incentive schemes don't even work because they don't really *reinforce* some hypothetical better self that really wants me to stop smoking. They simply "artificially" prevent me from smoking.

This skeptical argument appears quite ingenious: Some libertarians would favor incentives over legal prohibition or compulsion, because they leave room for choice. But the argument suggests that some incentives are coercive in a rather subtle way—the evidence for them being coercive is that once they are taken away, the behavior reverts to its former pattern. The misconception argument itself has two elements. The first is conceptual. It says that the reason the coercion argument here sketched fails is that people are not free autonomous subjects with reasonably robust sets of preferences that exist prior to our engagement with them. This model of psychological autonomy is incoherent. It depends on a model of the self which, since David Hume and Immanuel Kant, no philosopher can seriously subscribe to. I am not my preferences, nor are my preferences somehow constitutive of me and prior to my engagement in the social world. I have certain habitual traits and patterns of behavior and so on, but these are dynamic and shifting. There is no "authentic" self being traduced by these offers of incentives. To defeat the conceptual version of the misconception argument we need to supply an argument about the narrative coherence of the self which shows how a certain consistency in the stories we tell of ourselves is important morally, metaphysically, and practically (Korsgaard 2009).

This takes us to the second part of the misconception argument, which is empirical. Rather than theorizing about whether incentives normatively are coercive, and how people's preferences and behaviors change in the presence or absence of incentives of a certain kind, the claim here is that we need to do psychological experiments and build on psychological research which examines both what people actually do say about incentives, both as offered to themselves and as they are perceived when offered to third parties (in reality or hypothetically), and more importantly what they actually do in the context of incentive schemes and their alternatives. The flourishing emerging sciences of behavioral economics and experimental choice and decision theory are rich in such studies, though they are in the early days and most of the well known studies have rarely if ever been replicated. In a sense that point is *not* what these studies currently show, but rather that it is an empirical question, not a theoretical one, whether or not incentives are coercive; that is to say, whether they work through the same psychological mechanisms as paradigm cases of coercion. So far we have no reason to think that they do (Kahneman 2011).

Before moving on from coercion, we need to briefly consider incentives in the light of other more subtle kinds of influence: manipulation, persuasion, and nudging

(Wilkinson 2013). While the literature on the psychology and ethical issues relating to these kinds of influence is rich and growing, they are to some extent a distraction in the debate around incentives. To the extent that manipulation and nudging are attempts to trick subjects, to exploit their non-rational or imperfectly rational decision-making processes, incentive schemes are for the most part direct addresses to the person. The mode of address is essentially, "Here is something you want to do, but find difficult: How can we help?" In all the incentive schemes in health promotion that I have seen, there is a strong commitment both to explicit description of what the health behavior change sought is, why it is being sought, and the benefits and costs to the patient, and also of the incentive scheme itself, its structure, and how it is meant to assist the patient in changing his or her behavior. Informed consent *both* to the behavior change *and* to the incentive scheme is a central element.

There are two cases that do give us more pause for thought, however, and these relate to the relationship between incentives and persuasion. Persuasion seeks to influence the patient's thinking and behavior by giving explicit reasons, and seeking to have the patient take these up as her or his reasons for action (or desisting from action). As is well known, persuasion comes in many forms, and philosophers in particular are taught to be wary of rhetorical (as somehow distinguished from rational) persuasion. This can create difficulties when the patient's reasoning is either underdetermined or subject to strong non-rational influences. Consider the use of incentives in drug treatment (where it is more commonly known as "contingency management"). Here, a drug user will receive small payments each time he or she presents to treatment with a clean drug-testing sample, and a somewhat larger payment on successful completion of the program (rather like smoking cessation, but with the more complex social, legal, and psychological difficulties associated with unlawful drugs). Particularly for addictions to heroin and crack cocaine, the imperative to get hold of one's drug of choice can be very strong, and the person in treatment may be struggling rather desperately to stay clean and in treatment. It is often far from clear which of the patient's occurrent desires (to stay clean or get a fix) is predominant at any given time. He or she may seek the incentive both as a motivational aid to staying in treatment but also as a quick way to get money so as to get drugs (and thus drop out of treatment). The way the incentive tips and the impact it has in the context of the relationship with his or her clinician, are quite unpredictable. In this state of flux, it is not clear that the incentive acts as a reason or rational motivation in the right way.

Similarly, incentive schemes also exist to aid in keeping people with schizophrenia who live in the community in treatment; they can be offered small sums of money to attend clinics to receive depot injections of antipsychotic medication. The problem here is that they may be undecided as to whether they prefer the benefits of treatment over the harms of the side effects of treatment. The incentive may function as a way of stiffening their resolve to stay in treatment if they have decided that these benefits are what is important to them; or it may be that they tip their judgment in favor of treatment when the side effects are genuinely bad and they might otherwise drop out. The incentive acts to persuade them of the overall benefit of treatment. There is also the signaling effect: My clinician wishes me to stay in treatment and is giving me money to do so. The meaning of this in the context of the clinical relationship is subtle and complex. So in the drug treatment case, we may have situations where decision-making is less than rational, and the incentive is then processed in that unstable context; and in the schizophrenia treatment case it may resolve a conflict of values in a somewhat problematic

way. The point is that *if* there is a conflict of values, would we be happy that the incentive could be the tie-breaker? The defense of incentives is that they are intended to aid someone in sticking to a decision once they've made it. But does this defense carry over to the case where the incentive feeds into the decision itself (Szmukler 2009)?

Autonomy and Incentives: Dignity

Bearing this discussion in mind, we now turn to another dimension of autonomy. This is not the psychological dimension of autonomy given prominence in Mill and liberal moral theory, but the moral dimension of autonomy given prominence by Kant. The concept here is not autonomy as freedom, so much as autonomy as dignity (Korsgaard 2009). The central thought here is that what matters in autonomy is moral responsibility for one's own actions and behavior. In particular, we need to pay close attention to *doing the right thing for the right reason*. Consider our patient with schizophrenia, who is currently taking antipsychotic medication and is, in psychiatric terms, "well," but who is suffering from medication side effects, and is genuinely in doubt as to whether he or she prefers being "well" with side effects or "ill" without. He or she may consider that even when "ill" he or she is not all that ill, and so medication is at best a mixed blessing, and at worst an unnecessary harm. Participation in an incentive scheme is offered to aid in keeping patients in treatment. The explicit logic of the scheme is that patients in the community may forget to attend clinics, lead chaotic lifestyles, or otherwise drop out of treatment for lifestyle reasons. Our patient decides all things considered to participate in the scheme and continue in treatment. The incentive has resolved the conflict of values and decision-making uncertainty. Two questions of reason-giving arise here. The first is whether the incentive is the *patient's* reason or whether patient has, heteronomously, acted on someone else's reason or perhaps failed to act on a moral reason at all and simply given into a desire (here, for the money incentive). The second concerns whether, if we accept that the patient has acted on a reason, it is the right *kind* of reason.

I propose that we set aside the question of heteronomy. In this scenario, the role of trust, the clinician–patient relationship, the decision-making capacity of the patient, and the background conditions of potential coercive treatment (the patient could be subject to compulsory treatment under law if her or his behavior warranted it) are such that these fall under quite general questions of coercion and paternalism in medical and psychiatric care. Incentives are not a particularly illuminating detail in those debates. In a context in which medical care may be inherently coercive (as much psychiatric treatment is), incentives in themselves may be more or less coercive than other kinds of treatment, but only marginally so. Compulsory detention or long-acting drug implants are more coercive than an offer of money, even if that offer is perceived as being coercive other things being equal. We have already touched on these issues above. So to develop our understanding of the morality of incentives, it is more interesting to look at the second issue: From the point of view of law and psychology the patient is choosing autonomously; but from the point of view of morality, there is a difficult question about the relevance of kinds of reason to the moral evaluation of a course of action.

Recent philosophical scholarship has revisited this question quite forcefully (Crisp 2006). In particular, the idea is that there are certain kinds of decision in which money can and does play a part, but it should not. Thus, if I have a wealthy relative whom I do not much love, but who gives me cash presents when I visit, the moral quality of my decision to visit him is diminished by the thought that it is the money, rather than the

family bond, which motivates me to go. This argument has two basic forms. One is act-specific. The act itself is spoilt or corrupted by my offer or receipt of money where it does not belong. The other concerns the practice of which the act is an instance. By introducing money into a practice we corrupt the practice itself. No individual act may be corrupted, so to speak, but taken altogether, the set of acts constitutes the practice, and the practice loses or changes its moral quality. Take our HPV vaccination example for instance. One might feel that there is no particular wrong involved in offering a small incentive to any particular teenager to get vaccinated. However, if we come to expect that teenagers (and maybe others as well) will receive payments to be vaccinated, then the vision of vaccination as something which I do to protect myself, first of all, for my own sake, and second of all, to do my bit to promote the collective public health may be lost. It becomes something I do not want to do, and only do under sufferance, for a fee.

Some prominent commentators on incentives take this objection very seriously (for instance, Sandel 2012). However, it is very hard to substantiate. First of all, we can highlight an important feature of incentive schemes, which is that they carry meanings, and it is the meaning which is part of the mechanism. Consider smoking cessation schemes involving incentives. If they were simply "paying people to give up smoking," we have no reason to think that they would either be legitimate or justifiable. But, more importantly, there is no reason to think that they would work. There is no good reason to think that quitting smoking because I am paid to quit would be any more likely to succeed than quitting smoking because of the money I save by not smoking, or than simply trying to form my will not to smoke. Instead, we have to consider the form of the incentive and the way it works with the grain of individual psychology. An analogy can be made with going for a long run. I may set out to run a marathon. But a marathon is a long distance, and it takes a long time to complete. The pain and discouragement are present and real, the reward and pride are remote and imaginary. So, what many runners do is break down the distance into sections (quarter distance, half distance, laps, the distance to the next landmark, etc.) and focus on making it to the next waypoint, and then the next, until the race is run. Similarly, with smoking cessation, what incentives can do is set "waypoints" and small rewards to look forward to with an external party being responsible for confirming whether or not I've made it. It is the psychological structure which matters here, more than the money payments as such. The meaning of the payments and the way they fit into the resolve to quit smoking is more subtle than the critic has allowed, and it is not clear that, with this meaning in mind, the "practice" of smoking cessation has been corrupted.

Thus, while the corruption argument is telling and important, it is not general to all incentive schemes, from a conceptual point of view. Nor is it an a priori argument: It is an empirical one. It is a question of empirical sociology whether or not the introduction of incentive schemes in health promotion does have the consequences feared or not. This is a hard question to answer, either experimentally or using qualitative and historical methods. Insofar as empirical evidence exists, much of it is highly theory-laden in a non-trivial way (most studies rely rather uncritically on a distinction between intrinsic and extrinsic motivation which has rarely been articulated in any detail), and at least some points in the opposite direction. For example, "money" is not just one thing, with just one social significance; we have subtle ways of distinguishing gifts, tips, fees, or wages which depend on the context of giving, the identity and role of the donor, the scale of the sum involved, and so on (Zelizer 2011). It can be true that paying incentives to people can be a way to "govern" people, as Ruth W. Grant has suggested (Grant 2012). But it is not always true. And we don't currently have robust ways of sorting out good from

bad incentives as a matter of principle. This throws us back on context, and on local ideas of acceptability, and on concrete evidence of effectiveness and specific mechanisms of action. The impact of incentives on the clinician–patient relationship are complex, for instance: As with any other kind of intervention, incentives must be offered in ways consistent with good medical practice and medical ethics. What we need not assume is that incentives are *inherently* destructive of good clinical relationships or necessarily a poor *substitute* for such relationships, although of course they could, under the wrong circumstances, be both.

Fairness

Beyond the moral effects on the recipient of the incentive (and on the donor), arguments from fairness are important. Incentives in health behavior change might be *distributively* unfair. Some people either never practice the (adverse) health behavior in question, or take responsibility for their (positive) health behaviors, without the need to be incentivized. Yet because of this, they are not eligible for incentivization. Symmetrically, if the incentive were actually universal, so that everyone gets the incentive *unless* they fail to quit smoking or get vaccinated, we could make an argument from the unfairness of using an incentive as a penalty. In the former, limited incentive case, we might argue that those who need to benefit from the incentive scheme are being rewarded for "bad" behavior or weakness of will, and we might be concerned that we are creating a perverse incentive to take up a bad behavior in order to get the incentive. In the latter, universal but conditional incentive case, we might argue that those who fail to meet the condition are more likely to be seriously ill or socially vulnerable and we are reinforcing that vulnerability both by stigma and by denial of what is otherwise a universal benefit. Interestingly, some critics of targeted incentives also level this criticism: Incentive schemes for some kinds of health behavior change (e.g. smoking cessation in pregnancy) may be criticized for focusing on the relatively poor, and thus stigmatizing them, giving them money which it may be relatively hard to refuse because of their low baseline income, and labeling the behaviors of the poor as something in which the State will take an interest while leaving behaviors of the rich untouched. While there is something to this (if we think of the way smoking is now much more common in low-income groups than in high-income groups across the West), it is also the case that the State has a legitimate interest in trying to relieve inequalities in health, as it does in trying to relieve inequalities in status, opportunity, and wealth (Oliver and Brown 2012).

One way to answer these objections is to argue that incentives are not different from medicines: They are offered as an intervention to improve health. They are not properly analogous to welfare benefits, and the arguments about conditionality and distribution which arise in the welfare context do not apply. Moreover, the scale of incentives is not usually such that forgoing them represents a significant loss to the individual (in comparison with the costs of continuing to purchase cigarettes, for instance). The specific fairness objections relating to varieties of moral hazard depend in part on whether they *actually* happen, and moreover if someone is irrational enough to change their behavior in a direction which is harmful to them in order to benefit from small cash payments they would be eligible to receive if they (successfully!) change their behavior back, then it is the irrationality, rather than the unfairness, which is probably of more concern from a health promotion point of view. Finally, it is worth noting that in the limited social surveys which have been done on incentives in behavior change, most respondents place more

emphasis on the difficulty of achieving health behavior change than on the potential unfairness of making payments to people as a method for helping to bring about this change. So far as public acceptability is concerned, at least, it is more important to help people beat addictions (or serious mental health problems, or dangerous infectious diseases) with which they may need help than it is to worry about the relative *fairness* of different methods. Autonomy, however, remains central to any moral evaluation of incentives and indeed of behavior change programs more broadly (Promberger et al. 2011).

Related Topics

Chapter 19, "The Ethics of Incentives for Participation in Research: What's the Problem?" Alan Wertheimer
Chapter 21, "Autonomy," Catriona Mackenzie
Chapter 22, "Capacity and Competence," Jessica Berg and Katherine Shaw Makielski

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