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► To cite this version:

Philippe Batifoulier, Louise Braddock, Victor Duchesne, Ariane Ghirardello, John Latsis. “Targeting Lifestyle” Conditions: What Justifications for Treatment?. *Historical Social Research / Historische Sozialforschung*, 2021, 46 (1), pp.59-84. 10.12759/hsr.46.2021.1.59-84 . hal-03345323

HAL Id: hal-03345323

<https://hal.science/hal-03345323>

Submitted on 17 Sep 2021

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Veröffentlichungsversion / Published Version
Zeitschriftenartikel / journal article

Zur Verfügung gestellt in Kooperation mit / provided in cooperation with:
GESIS - Leibniz-Institut für Sozialwissenschaften

Empfohlene Zitierung / Suggested Citation:

Batifoulier, P., Braddock, L., Duchesne, V., Ghirardello, A., & Latsis, J. (2021). Targeting "Lifestyle" Conditions: What Justifications for Treatment? *Historical Social Research*, 46(1), 59-84. <https://doi.org/10.12759/hsr.46.2021.1.59-84>

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Targeting “Lifestyle” Conditions. What Justifications for Treatment?

*Philippe Batifoulier, Louise Braddock, Victor Duchesne,
Ariane Ghirardello & John Latsis**

Abstract: »Das Targeting von „Lifestyle“-Bedingungen. Welche Rechtfertigungen für die Behandlung?«. Patients suffering from “lifestyle” conditions are most often viewed as responsible for their illness, and so not considered to be a priority for healthcare resources. Instead, their treatment is financed on instrumental grounds: it is better to treat the condition now than to incur higher costs later of not doing so. An alternative register of justification at work in public healthcare policies is not motivated by instrumental considerations. Instead, it seeks to articulate an ethical case for prioritizing lifestyle conditions. Within this framework, we draw on the notion of vital need within the tradition of humanistic philosophy to argue that solidarity justifies the treatment of such conditions, exemplified here by obesity. We use the theoretical framework of economics of convention to present these two registers of justification at work in public healthcare policies. The importance of humanistic criticism prevents instrumental logic from being completely dominant.

Keywords: Economics of convention, orders of worth, obesity, health policy, vital need, targeting.

1. Introduction

In this article, we provide a normative justification for treating lifestyle conditions. These are medical conditions where issues of individual responsibility are cited as contributory and may be used in the justification of treatment decisions. There is a considerable financial burden associated

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with treating these conditions, which arises in a number of different ways. First, the problem (e.g., obesity or tobacco use) is constructed as an illness; here the role of the medical profession is important – if the condition is an illness it should be treated (Cookson and Dolan 2000; Korica and Molloy 2010). Second, there is a contribution from industry: for example, the food industry wishing to protect the “fat-business,” or the pharmaceutical industry preferring profitable chronic illnesses that require treatment to less profitable prevention strategies (Goryakin et al. 2015). Third, there is the instrumental economic argument that it will cost less to treat the condition now than in the future (Dobbs et al. 2014).¹

All these are negative reasons for treating lifestyle conditions and lack any apparent ethical basis. This goes some way to explaining why different countries have different tariffs for lifestyle conditions and why such conditions are seen as suspect and sufferers are often stigmatized. Moreover, in the instrumental argument, patients are segregated: the security of the healthy counts for more than that of the safety of the sick.

This instrumental conception is criticized for its “anti-humanism.” Prioritizing treatment of lifestyle conditions should be based on a “rule of rescue” (McKie and Richardson 2003). This justifies prioritization and replaces social separation with social connectedness.

The aim of this article is to analyze the justification of health policies, and particularly the financing of expenditures, within the framework of the economics of convention (EC). From this perspective, we consider that priority setting in healthcare is permeated by two competing conventions: an instrumental convention and a humanistic convention. Here, conventions are understood as a set of shared beliefs, inscribed in institutions, bound up with actions, and hence anchored in reality (Boltanski and Chiapello 2005). Conventions provide a basis for priority setting as well as for comparative criticism of competing conventions. Each convention conveys its own understanding of the common good², which is reflected in the resources it provides for justification, denunciation, and critiques (Boltanski and Thévenot 2006; Diaz-Bone and Salais 2011).

In this article, we first propose a conventionalist approach developing an alternative theory which attempts to challenge the incapacity of mainstream economics to deal with values (Batifoulier, Domin, and Gadreau 2011; Batifoulier, Braddock, and Latsis 2013; McMaster, Batifoulier, and Domin 2015; Batifoulier, Da Silva, and Duchesne 2019). We also draw inspiration from the Welfare Conventions Approach designed for understanding the “governmentality” of welfare and the processes of “welfare apparatuses” (Rose

¹ Though this ignores the contribution of healthcare expenditure to GDP and hence economic growth.

² We discuss in the text the status of the common good incorporated in each convention.

and Miller 1992). We view health policies as moral disputes and assume that priority setting in healthcare emanates from disputes and compromises between “orders of worth” (Chiapello and Knoll 2020).

In conventionalist analysis, the process of justification is based on the model of “orders of worth.” The “worth” (*cité*) model of Boltanski and Thévenot (2006) provides an analytical framework which enumerates the shared higher principles on which individuals’ justifications are based.

We also ground our argument in an ontological claim about human beings’ susceptibility to harm, where harm is understood as the impairment of those powers necessary for full human agency. Citizens look to just arrangements to protect themselves against the harm arising from circumstances beyond individual human control. The resources for protection, or failing that of mitigation of harm, are a good to which all human beings in a given community need to access in order to live with dignity in that community. Ensuring access to this protection is a matter of social justice.

Obesity provides a good test case, since it is a potential prime example for our analysis. The unequal status of obesity as a healthcare priority across jurisdictions indicates potential uncertainty about the normative basis for prioritizing treatment of the condition.

In section 2, we present our conventionalist approach to priority setting after characterizing the importance of obesity as an economic problem. In section 3, we review the current instrumental economic justification for treatment and its normative limitations. We refer to two objections: the argument from self-control and the argument from rationality. Section 4 presents our main argument. First, we assume that obesity is a social construction in order to set out the complex interdependence of physiological, psychological, and social causes of obesity. Then we elaborate our conception of harm and articulate the connection between protection from harm and vital needs, thus providing the ethical framework of the humanistic convention. Finally, a critique of instrumental logic is developed both on the basis of humanist logic and the economies of worth to show the limits of an approach based on individual responsibility.

2. Targeting “Lifestyle” Conditions: A Conceptual Framework

In this section we emphasize the construction of the problem of lifestyle diseases (2.1). We then propose a reading of health policies in terms of moral disputes by introducing the theoretical framework of EC (2.2).

2.1 Lifestyle Diseases as a Public Health Problem

Lifestyle-related diseases have emerged as the new priority of Western health systems since the early 1990s. This evolution is the result of different processes that characterize the evolution of public health policies.

The HealthBASKET program has developed an inventory of European health care services in order to delineate the services that are supplied by publicly funded health services in different member states. Comparative study emphasizes the similarities between states if we consider a very broad conception of service provision which focusses on the so-called “depth” of the health basket. However, it is not the case if we focus instead on the “height” of the basket – the proportion of the cost of goods and services charged to, or reimbursed by, the state or public institutions (Velasco-Garrido et al. 2006).

Some groups, such as children, adolescents, and pregnant women, benefit from prioritization policies everywhere. However, health services all over Europe have created, developed, or activated prioritization policies designed to privilege certain patient groups by protecting them from excessive financial outlays. This form of targeted solidarity has intensified with the introduction of market reforms designed to reduce expenditure (Van de Ven and Wynand 1996). Though health provision has always been targeted at certain groups, the erosion of solidarity has forced governments to justify current prioritization policies and develop new ones.

Priority setting in healthcare, in a context of budget shrinkage, began in the early 1990s, mainly in the United States and Great Britain, and then spread to other Western economies (Tenbensel 2000; Ham 1997). Their objective is to implement an order in which diseases should be treated by the health and social protection systems. Thus, a disease deemed medically less urgent will be treated after or be less reimbursed than a disease deemed urgent. This strategy makes it possible to smooth the demand for care according to existing health and budgetary capacities. On the other hand, it can lead to a renunciation of care or a worsening of the state of health.

This movement has been followed since the 2000s by the development of the issue of “non-communicable diseases” (NCD) or chronic non-communicable diseases as a central priority of health policies (WHO 2013; Beaglehole and Yach 2003). The “NCD” label thus groups together under the same name a group of diseases consisting of cardiovascular diseases, chronic respiratory infections, cancers, and diabetes. These diseases are presented as accounting for 71% of deaths worldwide. For some of them (heart disease, obesity, etc.), they have been considered as factors aggravating the risks associated with the development of COVID 19.³ The common factor for

³ <https://www.who.int/westernpacific/emergencies/covid-19/information/high-risk-groups>.

all these diseases is that they are related to lifestyle: smoking, sedentariness, etc. To address this, health policies resulting from the NCD crisis place most weight on modifying behavior.

These two movements, taken together, have been accompanied by an increased emphasis on the power of education systems and on the generalization of the concept of health determinants, with the aim of developing mechanisms for mobilizing and empowering populations so that they acquire the awareness and capacity to manage their health.

All of these approaches make the management of a significant proportion of the diseases of the 21st century based on individual responsibility and empowerment. This approach tends to ignore the social roots and economic origins of a disease. As a result, there is considerable controversy about the justifications for managing these lifestyle diseases.

2.2 Health Policies as Moral Disputes: The Theoretical Framework of Economics of Convention

Though we can see all three of these criteria in operation in the prioritization decisions taken by European countries, they are not sufficient for explaining the observed diversity in actual practice. The moral ideals underlying prioritization measures are translated into policy, in particular historical and political contexts. Health policies reflect the political arbitrage between moral ideals in competition with one another. No ideal can fully impose itself as fundamental at the expense of the others. In Europe, there are variations in both treatment and reimbursement policies with respect to lifestyle conditions (Nguyen-Kim et al. 2005), which suggests that there are different normative visions. Our goal in this section is to use the analytical framework of EC to provide a strong moral foundation for health policy rationales. We argue that convention theory provides a theoretical framework for these competing orders of justification.

The use of the theoretical framework of EC to analyze public health policies implemented from the 1980s makes it possible both to identify the overall coherence and legitimacy of these policies, and to explicitly link public policy mechanisms to the justifications that specifically underlie them. As in other fields, health policies are part of a neo-liberal shift seeking to develop market mechanisms and entrepreneurial logic on both the supply side (doctors) and the demand side (patients). These policies are part of a framework of tighter budgetary constraints, the restriction of public financial plan, and the development of the privatization of healthcare (André, Batifoulier, and Jansen-Ferreira 2016).

In this conception, the notion of individual responsibility plays an important role. Policies that seek to make the patient pay, for example, are

justified by the need to develop individual responsibility and for each person to manage his or her health.

There are limits to the costs of illness and in many countries, the patient is more often asked to contribute to the financing of part of his or her health costs, both in outpatient medicine and clinics. The highly “cost sharing” programs are put forward by governments because they make it possible to internalize the social cost of the patient’s behavior, they encourage a thrifty attitude to health expenditure, and they make it possible to combat fraud.

While this register of individual responsibility can be mobilized to justify health policies, it is not the only one. There are different registers of justification at work in public healthcare policies.

We assume that there is no unified vision of public health policy. As the EC argues, there are a small number of shared references that can be called conventions (Diaz-Bone and Favereau 2019). These conventions are collective representations of what a health care management policy should be.

According to the Welfare Conventions Approach, we study welfare state and the “governmentality” of welfare as moral disputes (Rose and Miller 1992). Healthcare policy is a matter of disputes that can be traced to conventions. Welfare conventions are ways of framing social problems identifying dedicated causes and solutions (Chiapello and Knoll 2020). Priority setting in healthcare emanates from moral disputes. Healthcare mechanisms and instruments are analyzed as embodiments of specific – and historically diverse – forms of justice and fairness (Boltanski and Thévenot 2006).

There is a controversy between different ways of providing health care and this controversy can be informed by the notion of convention. We limit the controversy to a binary view of health care financing. On the one hand, justification can refer to ethical grounds, valuing health as a fundamental and unconditional good. On the other hand, funding for care can be justified on purely instrumental grounds. Funding is conditional on the individual’s respect for their own responsibility. Individuals must bear part of the cost of care when their behavior is a source of expenditure. This register of justification is also a register of criticism and denounces scrounging as well as fraud and abuses. Individuals should not weigh on society, and health care financing is useful when it mitigates the costs of what would be more expensive tomorrow or when it leads to positive externalities.

For some treatments these concepts clash. This is particularly the case for lifestyle-related diseases where individual responsibility is emphasized. In the case of smoking, alcoholism, or obesity, for example, the behavior of individuals is emphasized and criticized. But health policies fund the healthcare that can be caused by these behaviors (e.g., lung cancer, cirrhosis, or obesity). They do so in the name of ethical justifications and the need to fight the disease. They also do it in the name of economic arguments. These chronic diseases have a high cost to society, which has to devote an

increasing proportion of (public) resources to their funding. These diseases generate negative externalities for people who are not ill. For example, passive smoking generates new healthcare costs, parental obesity affects the obesity of children, etc.

We propose to compare these two registers of justification with conventions, i.e., with different “orders of worth” (Boltanski and Thévenot 2006). Humanistic convention approximates to the “philanthropic convention” of Chiapello and Knoll (2020). It emphasizes the moral duty to help the most vulnerable. Instrumental convention is close to the “market convention” and aims at enabling everyone to act as an agent of the market. These two registers of justification are in competition. The approach of EC makes it possible to understand that the financial management of health care is based on different conventional visions. These conventions each define a particular form of organization of healthcare priorities.

As in the Welfare Conventions Approach, the two registers of justification that we identify at work in public healthcare policies provide a normative representation of acceptable working of social policy (here, priority setting in healthcare).

3. Instrumentality and Individual Responsibility

In this section, we develop the instrumental argument and the foundations of the convention that it supports. According to this convention, in the field of obesity management, it is better to treat the condition now than to incur higher costs later of not doing so. Utilitarian arguments emphasize individual responsibility in order to counter the “obesity epidemic” that is a “financial epidemic” (3.1). The instrumental justification for treating obesity and the emphasis on individual responsibility combine rational choice and moral considerations, which raises normative issues (3.2).

3.1 Instrumental Justification for Treating Obesity and Individual Responsibility

The idea of a “financial epidemic” fuels the instrumental economic argument. The underlying argument is that conditions such as obesity are dangerous for society because they threaten the financial equilibrium of health insurance. The foreseeable rise in costs requires more financial resources to be directed to these conditions. The excess cost is borne by public expenditure in Europe, and even to some extent in the USA. “One-unit increase in

BMI⁴ for every adult in the United States would increase annual public medical expenditures by \$6.0 billion” (MacEwan, Alston, and Okrent 2014, 696). Conversely, a reduction of the average BMI to below 25 would produce substantial savings.

Expanding obesity also has an impact on the expansion of the private healthcare insurance market. In the United States, where the medical costs of obesity have largely been borne by public programs (Medicaid and Medicare), private insurance costs have risen (Finkelstein, Graham, and Malhotra 2014). Obesity affects insurers’ profits and the actuarial calculation of risks. Inflating costs have brought back to prominence early, instrumentally motivated attempts by insurers to combat obesity in order to control expenses. In 1942, it was the Metropolitan Life Insurance Company, a private insurer that provided the first definition of BMI thresholds and published the first “ideal” weights for men and women.

In Europe, the high cost of chronic conditions has led to limits on allocations for other conditions in times of budgetary constraint. This is particularly so in France where illnesses linked to obesity are reimbursed at 100% (diabetes, hypertension), whereas for everyday care the limit is set at 55%. Obesity treatment therefore presents a problem for the non-obese. Aside from the public health issue, combating obesity is a matter of budgetary urgency. The risk attached to the condition is not, as with ordinary epidemics, a risk only for those who develop the illness; it is also a risk for those who do not. This purely instrumental argument makes a case for treating obesity in order to avoid penalizing the non-obese.

In fact, putting the financial security of the healthy rather than the suffering of the ill in the foreground goes against the logic of solidarity. This logic rests on the recognition that each individual belongs to a community and does not divide up the world into those who pay and those who receive. The notion of equal dignity amongst humans, which grounds the idea of solidarity, is further undermined by the perceived role of individual responsibility in the development of obesity. The argument from here on is well known. Uncontrolled eating without physical activity and “delinquent nutritional behavior” produce weight-gain. The wide acceptance of this narrative owes much to the predominance of the individualist approach which will be further developed in section 3.2.

Prevention of obesity in the home is often attempted through negative messages (about losing employment, for instance) rather than positive messages (effects on health and well-being). Healthy eating is presented as a means to weight loss rather than as a way to maintain good health long-term. Preoccupations about health, both individual and collective, appear to

⁴ The Body mass index (BMI) is a measure of body fat based on height and weight.

be relegated to the background by anti-fat remarks (“Don’t eat that, you’ll get fat!”; Thomas et al. 2014). The media accentuate this pejorative image by associating obese people with a range of difficulties. The “news media epidemiology” of obesity tends to over-represent non-whites and under-represent the older age groups, by comparison with their statistical prevalence (Gollust, Eboh, and Barry 2012).

Targeting obesity is thus justified by default, not by positive argument. Arguments from solidarity do not contribute to the dominant reasoning. The obese are presented as different from others, and their illness is that of someone “other.” Obesity is not seen as a condition (illness) that may affect anyone. The instrumental arguments for its treatment dominate the ethical ones.

The combination of health metrics (such as BMI) and financial metrics (budget ratios), on which instrumental health policies are designated to facilitate economic calculation and the allocation of scarce resources (Batifoulier, Latsis, and Merchiers 2009). They assume a unique type of calculative rationality that is characteristic of mainstream economics. The conventionalist approach has challenged and undermined this assumption by showing that calculation is dependent on justificatory frameworks (orders of worth) that are painstakingly established through social processes of negotiation (Boltanski and Thévenot 2006; Salais 2016; Diaz-Bone 2016). Conventionalists claim that calculation is dependent on social actors’ shared ability to group objects and people into equivalence classes which draw on the same format of relevant information, share a form of evaluation, recognize the same basic or elementary social relations, and prize similar individual characteristics (Boltanski and Thévenot 2006). Without constitutive conventions to frame coordination, cost benefit calculations are not possible. According to this theoretical perspective any valuations of worth imply a definition of the common good and shared values are the basic and inescapable precondition of all calculative activity.

The conjunction of an instrumental justification for treating obesity and the emphasis on individual responsibility may explain differences between public healthcare budgets. For example, France and the UK have both seen a large increase in the prevalence of obesity. In the UK, where obesity has doubled between 1985 and 1995, the media presentation of the epidemic is more marked and the healthcare budget allocation is higher. In France, only surgical treatment is reimbursed; obesity medication is not reimbursed and neither are dietary or psychological treatments. This discrepancy suggests that instrumental arguments have won the day when it comes to targeting obesity and ethical arguments are, at best, a background consideration.

3.2 Individual Responsibility and Its Normative Limitations

Many health conditions and the medical treatments associated with them are widely recognized across health systems as high-priority regardless of the method used to establish that priority, e.g., losing a limb or suffering from a debilitating genetic disorder. In most of these cases we can assume that establishing the presence of serious harm is relatively uncontroversial. However, as we saw in the case of lifestyle-related diseases, there are health conditions that are treated differently by different healthcare providers and for which prioritization is a controversial and sensitive topic. Communal acceptance of these conditions as worthy of targeting is patchy, and ethical arguments (as opposed to instrumental arguments) for provision are left largely unarticulated. Obesity is just such a case, along with others of the so-called “lifestyle conditions” produced by tobacco, drug, and alcohol abuse. Prioritizing these conditions, and in particular, extending costly and complex medication, treatment, and services to those who suffer from them, faces at least two well-articulated objections. The first draws on moral intuitions, whilst the second arises from economic calculation.

We shall refer to the first objection as the *argument from self-control*. According to this objection, lifestyle conditions, insofar as they result from consumption activity (e.g., eating, smoking, drinking alcohol, or taking narcotics), are the primary responsibility of the patient. Where regulation and information about health risks is widely available and clearly indicates the risks associated with consumption, there is a tendency to stigmatize many of those who suffer from lifestyle conditions as having (avoidable) “bad” habits, which led to their illness. Though they may become both involuntary and difficult to shed, the formation and persistence of these habits can be seen as the result of a specifically moral flaw – lack of self-control – inherent in the individual suffering from the condition.

The second objection draws on mainstream economics and rational choice social science rather than explicitly moral considerations; we refer to it as the *argument from rationality*. According to this view rational agents choose what they prefer and reveal their preferences through their choices. Thus, in a situation where adequate information about the consequences of consumption is available, what we interpret as harmful or “overconsumption” should be seen as rational action carried out by a sovereign consumer. More extreme versions of this argument would then regard any attempt to modify behavior through intervention, regulation, or incentives as unjustified and paternalistic.

At first glance, the two positions presented above seem to adopt contradictory perspectives. The moral argument implies that health outcomes are the consequence of irrational choices made by individuals lacking the virtue of self-control, whilst the economic argument sees health outcomes as the

consequence of rational choices made by individuals seeking to maximize utility. However, these *prima facie* differences mask an underlying similarity: they both conceptualize the individual agent as an *isolated consumer*. That is, rather than taking into account the institutional context, social relations, and affective ties that are constitutive of real patients, individuals are seen principally as choosers with bundles of pre-assigned preferences. This view of individuals as isolated consumers then leads readily to the “liberal” conclusion that lifestyle conditions are problems of individual responsibility that should be addressed and solved by the individuals concerned. Thus, in the case of the argument from self-control, people who lack self-control should take charge of their lives by developing systems of rules and commitments to overcome their weakness(es). And, in the case of the argument from rationality, consumers are rational and their choices reveal their preferences, so their health outcomes are (in some sense) desired or at least deserved. In both cases, individual moral or cognitive characteristics rather than chance are deemed to be at the root of lifestyle conditions.

More importantly, if one or both of these objections hold, then it is no longer obvious why the community as a whole should be held responsible for the alleged excesses of some of its (supposedly well-informed) members. There is empirical evidence of variation in both treatment and reimbursement policies with respect to lifestyle conditions (Nguyen-Kim et al. 2005; Vemer et al. 2010), which might indicate sensitivity on the part of healthcare providers to the two arguments outlined above, though there are countervailing tendencies and the link has not yet been made explicit.

4. An Impossible Instrumental Health Strategy: A Clarification through Humanist Criticism

This section criticizes the instrumental argument from a humanistic point of view. It insists on the social conditions of obesity that modify the moral argument (4.1). Our objective in section 4.2 is to use the analytical framework introduced in Batifoulrier, Braddock, and Latsis (2013) to articulate a firm moral grounding to counter instrumental justifications. We argue that those who suffer from lifestyle conditions are subject to serious harm, which justifies communal intervention on their behalf. We combine humanistic philosophy with the framework of EC to show that the instrumental logic is more a process of legitimization than legitimacy (4.3).

4.1 Obesity as Social Construction

Social scientists have studied the mechanisms that aid the development and maintenance of future regarding behavior in some depth and their results

can readily be connected to the obesity epidemic. Discussion of the social determinants of obesity is widely documented in the social science literature, with a variety of complementary arguments being put forward in recent years. Many scholars show how individual decisions are embedded in social structures and lifestyles cannot be described independently of context (Cockerham 2013, 2005; Cockerham and Hinote 2009; Cockerham, Rütten, and Abel 1997). Moreover, the self-determination and autonomy emphasized in the individualist paradigm have been shown to be conditioned by the material conditions of existence (Reilly et al. 2014). It has even been claimed that individual action is not dispersed among social determinants but embedded in the *habitus* (see Bourdieu 1984) through which individuals internalize social structures. So, for example, weight gain is not seen as a problem in all social classes, and is mainly a problem for the leisure class; the image of the “body beautiful” is differentially distributed (e.g., the social or professional environment can increase the pressure to be thin, for example amongst female trainees). This is reinforced by the fact that cultural perceptions differ over what counts as good food: flavor for some, health for others (as with the preference for “organic” food): healthy eating is seen differently by different social groups, and lifestyle conditions are linked to socioeconomic class (Cockerham 2005).

When it comes to obesity, neither healthy eating nor physical exercise is a product of the free choice of the individual. They rest on different levels of economic, social, and cultural capital, which themselves produce different attitudes. Educational level will affect the ability to control intake; someone with such “cultural capital” better understands the negative effects of large helpings or fatty foods, and the significance of food labelling and warnings (Christensen and Carpiano 2014). Moreover, food insecurity itself is a major cause of disorganized eating behaviors, as shown by a recent French study of women receiving food assistance (Vernay et al. 2014). Nutritional imbalance is tied to the fear of going without, which leads to increased nutritional imbalance for mothers and children.

In an influential study of consumption in the US and UK since 1950 (Offer 2006), Avner Offer coined the term *commitment technologies* to describe the resources used by individuals to resist the pull of short-term rewards such as those described above. Giving the example of a student deciding whether to spend the evening at her desk or go out with friends, he explains how the decision to behave consistently with long-term interests (and stay at her desk) is facilitated by features of the student’s environment such as teaching schedules, exam timetables, and parental expectations (Offer 2006, 3). Commitment technologies are also implicit in several pioneering contributions to sociology. Norbert Elias (1978) and Bourdieu (1984) both analyzed the development of conventions of bourgeois table manners in Europe as increases in food production began to enable consumption beyond the min-

imum needed for subsistence. Scholars have hypothesized that an important explanation for the existence of rules of etiquette surrounding food is that they are a ritualistic mechanism of self-control in an unfamiliar environment of relative affluence. The evolution of bourgeois table manners can thus been seen as part of an overarching quasi-functionalist narrative, where commitment technologies are developed to cope with the consequences of greater affluence (Offer 2006, 143).⁵

It is here that Offer breaks with previous scholarship by showing how affluence in the West has created a regressive social dynamic that leads to a decline in wellbeing. In the case of obesity, Offer cites a host of familiar physiological and social factors that can be used to explain increased body weight: availability and quality of food, breakdown of family meals, increased work hours, stress and time pressure, and the reduction in manual jobs, to mention just a few (Offer 2006, 144-51). These conditions present consumers with a tempting array of high-calorie food that is both heavily marketed and ubiquitously available. Worse still, most people lack the necessary resources to resist temptation because there is a time lag between the development of the productive technologies that make more and different types of food available, and the creation of stable and widespread commitment technologies that facilitate self-control. The next step of Offer's account is plausible though somewhat mechanistic: whichever commitment technologies have been constructed to counter the "obesity epidemic" (diets, low-fat food, exercise regimes) are a scarce and expensive resource that can only be acquired by wealthier and better-educated people. In this way, Offer relates the speed of technological change and rising income inequality to the observed rapid increase in average body weight in the UK and US. He also provides a ready explanation for the unequal distribution of weight gain within populations, positing a mechanism that connects socioeconomic status and obesity through the mechanism of an acquired capacity to exercise self-control.

The conclusion from all of this must be that obesity is a medical condition with actual and potential deleterious effects on the individual's physical and psychological health, and that it is above all a disease of social vulnerability.

⁵ Work on intergenerational transmission of lifestyle conditions has confirmed Offer's analysis. Studies of childhood obesity have shown how, in the absence of parental control and in the presence of children's ability to negotiate, obesity is linked to the social status of the family (Ehmke et al. 2008). As with health inequalities in general, there is a social gradient of obesity in children. Intergenerational transmission of lifestyle is accompanied by obesity in the most vulnerable parts of the population. For example, the income of parents is the best predictor of childhood obesity in Spain (Costa-Font and Gil 2013). There is thus an unequal risk of becoming obese since the social milieu of origin has a long-term effect on health by affecting adult health (Khlát, Jusot, and Ville 2009; Bricard, Jusot, and Tubeuf 2010). All these factors make individual decision-making highly relative to context and conditions, and justify a more consistent approach to funding treatment.

Hence, the contribution of individual responsibility and decision-making in nutrition must be seen in the context of factors that are to a varying and often a very large extent outside the control of the individual. Social origins, social and economic context, and life circumstances relating to the management of nutrition must all be taken into account.

4.2 Health as a Vital Need and the Concept of Common Ground

We have previously argued that differential healthcare resource allocations, including differences in targeting and prioritization, can be explained in terms of the socially and psychologically constructed dimension of healthcare needs (Batifoulier, Braddock, and Latsis 2013). Different values will guide the construction of these “thick” healthcare needs and hence, implicitly or explicitly, inform such differentials.

Variation in healthcare priorities across different communities is not arbitrary if priorities can be normatively grounded in the values of the communities that adopt them. To be legitimate, such priorities must meet two conditions. First, they must possess a universal dimension grounded in general human concerns. We will argue that, in the case of healthcare, this universality lies in the intent to protect the community's members from harm. Second, and crucially, since harm can befall any member by chance and through events beyond their control, priorities cannot be solely established by calculation of individual or group risk and responsibility. Priorities must be consistent with (and in principle should reflect) the community's conception of the common good.⁶

Avoiding or mitigating the harm of ill-health is the key to understanding the universal dimension of prioritization. In order to articulate and clarify this idea further, we employ David Wiggins' concept of vital need as a need that must be met if serious harm to the individual is to be avoided or mitigated (Wiggins 2005, 1987). Our understanding of the idea of human harm is drawn from the thought of humanistic philosophers such as Wiggins, Alasdair MacIntyre, and Bernard Williams. In the human context, “serious harm” is the loss of agentive power: the diminution of the individual's power to act in the natural and the social world in a way that is physically efficient, rationally effective, and within individual control. What makes the human being an agent is the power of active, intentional, and autonomous engagement with the world and to lose this agentive power is to lose a part of what it is to live a human life. Construing serious harm in this way then provides a generalizable basis for assessing healthcare needs as vital needs: a

⁶ Here, the notion of common good is linked to the concept of vital need. It is both different from and close to the notion of common good used in economies of worth. We will come back to this in the last part.

healthcare need is a vital need when meeting it will avoid, or mitigate, the harm of diminution or loss of a subject's agentive power. The harm formulation is also sensitive to contingent variation in the historical, material, and technological conditions faced by a community. It explicitly allows for the specification of what counts as harm in a given community to be filled in, both from attitudes and values expressed by its members and by reference to the way its social arrangements and extant communal practices offer protection against harm and so, embody conceptions of the common good.⁷

Our emphasis on harm as the prior concept around which to organize an ethics of resource allocation implies important differences from the capabilities approach of Sen and Nussbaum, despite the fact that something like our concept of agentive power can be found in the capabilities literature. The differences are seen both in the focus of concern and in the priorities of philosophical analysis. In respect of focus, both the theoretical lens and the practical goal of the capabilities approach are centered on the idea of freedom as development, and hence the analytic emphasis is on capability as "effective freedom," the freedom to deploy human abilities without coercion, and with means and opportunity. Furthermore, health has a secondary role as instrumental in achieving development goals.

By contrast, our own focus is to develop a solid ethical basis for healthcare economics, including a theoretical apparatus that can recognize and acknowledge both the variety and the complexity of the values implicated in healthcare provision. Our conception of agentive power as constitutive of humanness is logically prior to the possession of capabilities. Harm is to be defined not in terms of impaired flourishing or realizing of potential but in terms of impaired humanity; not in terms of the possibilities for development and freedom, but in terms of what it is to "be" a person in terms of one's physical, psychological, and social agentive powers. Agentive power is a condition of possibility of freedom and so a condition of possibility of capability.

On our interpretation of serious harm as the impairment of human agency, it is a harm that ill-health, among other causes, can bring about. Healthcare needs are vital when what they require will prevent the serious harm of becoming impaired as a fully agentive human being. By categorizing healthcare needs as vital needs, and consequently the harm that accrues from their not being met as serious harm to the human capacity for agency, we provide an ethical justification for prioritization grounded in the tradi-

⁷ This conception is close to the works that criticize the application of the biomedical model for which all illnesses are either mainly or exclusively a consequence of some disruption to or malfunction of the biological process. On the contrary, the conventionalist thesis (Da Silva 2017, 2018), related to the Canguilhem thesis (Diaz-Bone 2021), wants to show a plurality of forms of representation of health and disease.

tion of humanistic philosophy. We also provide a workable criterion that can be applied case by case, individual by individual, and community by community to determine whether a healthcare need is for something that will restore, or arrest, the ongoing impairment of agency for that individual in that community.

This allows us to give specific content to the definition of the common good as that which all members of a community must have access to in order to live with dignity in that community. As such, our proposal is that “to live with dignity” means to possess agentive power. Thus, the resources to protect this status are what “all members of the community must have access to” in order to live with dignity. So the common good at issue in healthcare denotes those resources which will mitigate the harm of impaired agentive power.

It is important to acknowledge that in linking healthcare resource prioritization to the common good of protection from harm, we are making a strong claim about the nature of the values that inform priority-setting and about the methodology to be employed to determine these. While empirical studies of national differences in priorities cite differences in “societal values,” operational definitions (such as NICE’s “judgements of social value”)⁸ in such empirical ethical studies cannot be values in our terms since they are utilitarian calculations of ideal situations. Here, as Sen points out (though without advocating a common good approach), when societal values are equated with utilitarian calculations of subjective preferences indexed to idealized situations, they exclude both important dimensions of variability within communities and prior ethical considerations for that, or for any, community (e.g., Sen 2001). Furthermore, and importantly for our harm-based approach, utilitarian calculations – in common with Rawlsian deliberation (Wiggins 2005, 35, 38) – do not take into account the value attached to what is assumed prior to calculation: that circumstances prejudicial to preference formation do not obtain. Thus neither utilitarian calculation nor Rawlsian deliberation can accommodate, within the frame of subjective interest, the norms of reciprocity and support that realize the community’s values, including its ideas of the common good, by welding practices into a coherent social whole and make possible its way of life.

Our position is in fact stronger than this because, on the common good approach that we advocate, utilitarian calculation is excluded as formally incompatible. A common good for a community is one the community itself creates and maintains through its practices, to which all its members have

⁸ The National Institute for Health and Clinical Excellence (NICE) in the UK, the Haute Autorité de Santé (HAS) in France, or the Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen (IQWiG) in Germany provide national guidance and have sought to legitimate rationing measures by making them compatible with judgements of social value.

access and for whom it is only an individual good because of its commonality: a common good is neither “reducible” to nor “constructible” from individual goods. In this conception of the common good we follow MacIntyre (1999), for whom a common good is mutually constituted between community and individuals and is intended as such; it is a good about which members of the community have a common, shared mind and purpose. Its value is as a good essentially and indivisibly shared; as, and only as, a good held by the community that is a good for each of its members. A common good approach excludes a utilitarian construal of societal values as formally inconsistent since, MacIntyre points out, societal values that derive from the common good thus understood cannot be equated with atomized subjective interests.

4.3 Is it Sustainable to Justify the Treatment of Obesity Based on Market Logic?

As we have seen, the two types of justification for health policies on obesity can be opposed. On the one hand, there is an approach that borrows from market logic and advocates patient management based on individual responsibility. On the other hand, there is a humanistic and critical approach that considers care as non-negotiable and is based on collective management of patients taking into account their vital needs.

These two approaches might be thought to be complementary through sharing a legitimate common objective (the improvement of the health status of individuals) even while differing greatly in the means to achieve it. They might also seem to be linked together, because market logic will appear to accommodate some of the criticism it invites from the humanistic approach. In this last section, our objective will therefore be to show that market logic, confronted with humanistic principles, is forced to adapt itself in order to resist the latter’s criticism. To do so, it lays claim to principles of legitimacy intended to validate the market regime’s axiomatic structure (Boltanski and Thévenot 2006), which our immanent critique shows to be no more than *legitimizing* principles to which it is not entitled.

Market logic was developed with the neo-liberal turn of the 1980s: it is budgetary constraint that highlights the imperative of individual responsibility. Health is considered as a capital that must be maintained or made to bear fruit in the same way as financial capital. This situation leads to a paradox: although the market concept of health is the subject of much criticism, it is in constant development (Batifoulrier 2014; Batifoulrier and Domin 2015). We formulate the hypothesis that if the market conception resists criticism, it is precisely because it manages to present itself in the register of market justification described by Boltanski and Thévenot. Instrumental policy is based on the budgetary savings it would allow. However, it also needs moral

justification. It then rehabilitates itself by taking over the arguments of legitimacy from the axiomatic of worth (*cité*).

As we have seen above, the process of justification in conventionalist analysis is based on the model of economies of worth. The “worth” (*cité*) model of Boltanski and Thévenot (2006) provides an analytical framework, resting on the main modern Western political philosophies, which enumerates the shared higher principles on which individuals’ justifications are based. These principles are considered legitimate insofar as they respect six axioms that guarantee both a principle of equivalence between them and a general scope.

Instrumental health policy seems, at least on the surface, to respect this axiomatic structure. *The axiom of common humanity (a1)* is respected in the sense that men, who cannot be the object of commercial exchange, all have the same right to health even if they are considered to cause their own pathology because of their individual behavior. *The principle of dissimilarity (a2)* can be interpreted as the taking into account of differences in initial state of health justifying, where appropriate, different forms of treatment: individual responsibility for some, collective benevolence for others. *The principle of common dignity (a3)* can be translated as the fact that a person can improve his or her health capital, which gives them “an identical power of access to all states.” *The principle of magnitude (a4)* associates each state to a scale of values. Here it goes without saying that being healthy is a high-ranking state while poor health will be rated as low-ranking. *The investment formula (a5)* is respected in the sense that the good health of high-ranking people is linked to investment, effort, and individual responsibility. Finally, *the common good (a6)* is understood as the principle that the wellbeing of the “worthy” must benefit the “unworthy,” in particular the low-ranking (those in poor health) insofar as, through their wise management, they will make less demands on collective health expenditure and will therefore reduce the pressure of budgetary constraints on the determination of health policies.

This exercise suggests that the axiomatic applied to health through the market prism can be respected. However, several internal contradictions undermine this conclusion.

First with respect to *a1*, it should be noted that individual responsibility and the axiom of common humanity are in tension; if the requirement for individual responsibility justifies the absence of care during the lifetime of a part of the population because of their individual behavior, we find nevertheless that when the ultimate consequence of the disease appears, this same individual responsibility no longer applies. In other words, the theme of responsibility weighs on the management of obesity and lifestyle-related pathologies but is cancelled once the disease becomes serious and life threatening. Thus, you will not be reimbursed for treating your obesity because it is your fault. But the amputation and fitting of a prosthetic leg

that you are going to undergo because of the diabetes triggered by your obesity will be reimbursed even though the cause is supposed to be your responsibility. This attitude to therapeutic intervention is indispensable if we respect the principle of common humanity, which cannot leave people to die from a failure of individual responsibility. However, if one follows the standard economic theory and instrumental approach that insist on individual responsibility, one should let these people die. We should do so all the more since the cost of health care is concentrated at the end of life or at the time of critical episodes in life. Thus, if we consider the ultimate consequences of illness, the prospect of budget savings is socially unsustainable because it implies letting fellow human beings die.

We may ask why it is impossible to disobey the taboo of death when it would be rational to do so (Tirole 2013). The sacredness, and the social centrality of health, are undeniable in contemporary Western societies. This implies that instrumental logic is not only based on an economic objective of reducing public expenditure, but is permeable to principles of justice that are indispensable when dealing with health issues, which is a primary natural good in Rawls' terminology. This is why the principle of individual responsibility cannot be consistently applied. It is only by renouncing the implementation of its own principles that individual responsibility can, by taking care not to offend the principle of common humanity, hope to resist criticism and thus to persist in appearing as a justificatory principle.

A similar inconsistency is evident with respect to *a3*, where the principle of common dignity is respected only in appearance and at the expense of an obvious distortion. Even while accepting that the most vulnerable benefit both from the advantages of individual responsibility and from the management of their pathology through collective resources, it is by no means certain that this will enable them to attain high-ranking status. Health states do not only depend on individual practices but also on social factors and unavoidable contingencies. Just as there is type 1 diabetes, which is an autoimmune disease, it is now accepted that obesity can have hereditary and/or genetic foundations, as well as the socioeconomic determinants we have foregrounded. Because a number of these pathologies are incurable or unavoidable, the principle of common dignity is limited by the fact that there is no such thing as "identical power of access" to health itself.

Thirdly, both the principle of dissimilarity (*a2*) and the principle of common good (*a6*) are in tension with the existence of a "responsibility trap" as a harmful effect of a health market policy in which insistence on individual responsibility carries moral weight. If an individual pays attention to his or her lifestyle, it improves health and frees up resources for others. On the other hand, if the individual does not do so and his or her health is poor, the blame lies with the individual. Many current public health policies implicitly concur with this argument, and reimburse little or nothing as compensa-

tion for these diseases. In this context, following the market logic is tantamount to placing the blame on the sick themselves. This is a dubious conception of legitimacy in any case. It is certainly one that contradicts the principle of dissimilarity which requires accepting the otherness of all people regardless of their initial state of health and individual capacities. It is also incompatible with the principle of the common good, in “blaming” the lesser-ranked and shifting responsibility away from the collective.

It is not only, then, that in the field of health the logic of budgetary constraint cannot by itself be a sufficient justification. Our critique shows that the logic of individual responsibility, while it mobilizes the grammar of market justification, does not sit at all well in a regime of justification even when, under the pressure of humanist logic, it adopts the regime’s arguments of legitimacy in order to deflect criticism.

It is the notion of vital need which allows us to move away from this situation. Recognizing health as a vital need means that it is no longer simply a form of capital to be made to bear fruit. While social inequalities in economic wealth can potentially be overcome by the accumulation of wealth, those related to health can never be overcome. Health does not accumulate, at best, it is preserved. Thus, an inequality of birth or position acquired at a given point in life because of an accident or lack of care can hardly be made up for. Poor health influences all spheres of economic and social life.

The rise in inequalities with neoliberalism, and the contribution of social scientific work showing the existence of a social gradient in health states, for example in the case of obesity (Darmon 2008), underlines how the market logic, applied to health, fails to constitute a “worth” (*cité*). At the same time, as various conventionalist studies have shown, the stability of a convention can go hand in hand with the maintenance of a certain level of inequality, or even injustice. Work on the concept of “bad convention” (Larquier and Batifoulrier 2005; Batifoulrier 2015; Larquier 2016) highlights the fact that certain conceptions or ideas acquire conventional status even though they are denounced because of their inefficiency or unfairness. Similarly, discriminatory practices may be fundamentally unjust but persist (Ghirardello 2019).

In health, the argument of individual responsibility, which underlies the market orientation of health policies, has been adept at incorporating criticism in order to endure. This makes it possible to understand why the market logic remains when it allows social inequalities to persist. But this logic’s force is owed to transactions of legitimization, not to principles of legitimacy guaranteed by conventions.

5. Conclusion

Lifestyle conditions are clearly harmful in the sense that they impair human agency in significant ways. The physiological aspects of harm in the case of obesity, alcoholism, or tobacco addiction are well known, and the physical and psychological handicaps that they impose clearly impinge upon agentive powers. But lifestyle conditions also lead to harm in a broader sociological sense which goes beyond the medical definition of disease. Empirical patterns do not establish a causal link, but they do emphasize the remarkable array of status-related problems that obese individuals face in reality and show correlations between obesity and reduced professional and marital opportunities, lower income, and a number of other socioeconomic issues (Offer 2006).

We have identified two approaches to giving priority to living conditions. These two approaches are shared references that can be called conventions, according to the theoretical framework of EC. The two registers of justification are in competition.

To prioritizing lifestyle conditions, the first approach is instrumental. This approach views the patient as an isolated consumer who is responsible for her own medical predicament. Prioritizing the needs of such a patient can nevertheless be justified, but the justification is the direct result of a utilitarian cost calculation. Policy measures are introduced because they are consistent with the market-oriented healthcare reform of recent years (Mooney 2012) and, more specifically, because they are deemed to be less expensive and more efficient than the alternative of treating the longer term effects of lifestyle conditions. This may explain why several European healthcare authorities have targeted lifestyle conditions like tobacco use and obesity, often at great cost to publicly funded health budgets.

In contrast, the second approach is not motivated by instrumental considerations. Instead, it seeks to articulate an ethical case for prioritizing lifestyle conditions. On the premise that ill-health, and the harm it brings, are a result of chance for the individual, one such chance is the physical and social environment in which the individual is born and raised, including the incident of birth itself. Another is the individual's physical and psychological endowment. The opportunities for developing and using these are then contingencies which are path-dependent with respect to social, political, and economic factors which are themselves largely beyond the individual's control. If it is opportunity that brings about ill-health and ill-health is, as we argue, a form of harm (specifically the harm that comes from vitiation of agentive power), then the role of social justice is to guard against this. Targeting is justified because it realizes the common good of protection from

such harm visited on individuals as a matter of chance, and helps preserve their agentive status.

However, these two registers of justification are not on the same level. As we have shown, health is not just a capital that the individual is responsible for. Even if this point of view is present in social health policy, it goes hand in hand with the development of major inequalities, of which obesity provides an emblematic case study.

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All articles published in HSR Special Issue 46 (2021) 1:
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doi: [10.12759/hsr.46.2021.1.136-159](https://doi.org/10.12759/hsr.46.2021.1.136-159)

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Valeska Cappel

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