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Shared health governance: the potential danger of oppressive "healthism"

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Abstract
We share an interest in public health and in the capabilities approach developed by Amartya Sen, Martha Nussbaum, and others (Comim, Qizilbash, and Alkire 2008; Sen 2009; Nussbaum 1999), so were curious to see how Jennifer Prah Ruger would apply her "health capability paradigm" to health governance. The resulting model-shared health governance (SHG)-has real potential to promote justice in health in some contexts. However, based on the description provided in this issue (Ruger 2011), aspects of SHG seem at odds with important features of the capabilities approach. We suggest that SHG will better safeguard the freedoms of individuals-including their health capabilities-if modified in two ways: (1) if the scope of application is reduced, and (2) if a focus on capabilities for health rather than achievements of health is more consistently maintained.

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Shared Health Governance: The Potential Danger of Oppressive “Healthism”

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We share an interest in public health and in the capabilities approach developed by Amartya Sen, Martha Nussbaum, and others (Comim, Qizilbash, and Alkire 2008; Sen 2009; Nussbaum 1999), so were curious to see how Jennifer Prah Ruger would apply her “health capability paradigm” to health governance. The resulting model—shared health governance (SHG)—has real potential to promote justice in health in some contexts. However, based on the description provided in this issue (Ruger 2011), aspects of SHG seem at odds with important features of the capabilities approach. We suggest that SHG will better safeguard the freedoms of individuals—including their health capabilities—if modified in two ways: (1) if the scope of application is reduced, and (2) if a focus on capabilities for health rather than achievements of health is more consistently maintained.

Shared health governance seems a plausible model for ensuring that macro- and meso-level health care systems can support capability for health for all. For example, it seems well suited to safeguarding basic health care services for all sick people, regardless of their wealth. As Ruger has argued, just and equitable health care provision requires resource sharing, fair and efficient distributions, and limits on self-interest maximization; all are entailed in SHG. Examples of collectively guided health service delivery—such as Local Health Integration Networks in Ontario, Canada (MASS LBP 2009)—suggest that SHG may be practically feasible for Address correspondence to Stacy M. Carter, The University of Sydney, Centre for Values, Ethics and the Law in Medicine and Sydney School of Public Health, K25 Building 1 Level 1,Medical Foundation Building, Sydney 2006, Australia. E-mail: stacy.carter@sydney.edu.au this purpose. SHG may also be relevant for other macro- and meso-level systems that influence capabilities for health: for example, systems for providing public transport, food, and basic education.

We would have little argument with Ruger’s SHG if it were limited to the governance of macro- and meso-level systems and services. As currently presented, however, SHG is also a system for governing individual persons. For example, it “entails individuals taking action to improve their own health . . . as well as that of others” (32). It is this potential application of SHG to health promotion at the level of personal health care or self-care that we think is especially problematic.

Ruger’s SHG model is underpinned by a “health capability paradigm”; Ruger aims to produce societies in which “all people can realise central health capabilities” (32). This we think appropriate and consistent with a broad capabilities approach. In Ruger’s current paper, however, there is significant slippage from the goal of creating conditions in which all people are able to be healthy to the goal of requiring all individuals to act so as to be healthy. This drift from capabilities for health toward achievement of health may sacrifice protection of important individual freedoms, one of the great assets of the capabilities approach. Ruger also emphasizes enforced obligations: particularly obligations on individuals to
internalize and act in accordance with “shared moral norms.” The combination of obligations and a focus on individual achievement seems likely to limit human freedoms. It appears that in SHG we are not free to be or to do as we might individually have reason to value being or doing, as regards our own health or more generally.

Will this lack of protection of freedoms in SHG have practical implications? This may be determined by three factors: (1) how “health” is defined and understood; (2) the scope and flexibility of the collectively agreed “permissible moral beliefs” at the heart of SHG; and (3) how conformity is encouraged or enforced.

The definition of health and the “permissible moral beliefs” within SHG are determined by a process for securing “consensus and congruence on values and goals.” Ruger acknowledges that she has not defined the process for consensus. We believe, however, that SHG cannot be evaluated without an understanding of the consensus process, for two reasons: (1) The process itself could undermine the normative individualism that SHG aspires to (Robeyns 2008); and (2) the “shared moral norms” generated would shape the obligations and freedoms that individuals have under SHG.

Regarding the consensus process itself: it is currently unclear who might participate and how this might occur. In the current paper, Ruger presents lay people in conflicting ways: sometimes as participants in “authentic joint problem solving,” sometimes as “add[ing] inefficiency, irrationality, and incoherence to health policy decision making” (32). Conversely, scientists and “experts” appear to be trusted more than history would suggest is wise, with little recognition of the value norms that underlie the generation of evidence (Molewijk et al. 2003). We know that disadvantaged people are less compliant with government-endorsed “healthy lifestyle” advice and potentially less well prepared for civic engagement. There seems a considerable danger that they may be dismissed as “irrational” or “incoherent” and thus remain unrepresented in the “consensus.”

This is not the only threat to the hoped-for “spontaneous convergence” on “shared moral norms” in SHG. The central health capabilities that Ruger identifies—to avoid premature death and escapable morbidity—are likely to command broad general support; however, these are highly abstracted. To apply them to any particular situation would require considerable extension and refinement. It would be difficult to achieve consensus nationally or locally about capabilities for health that people should be obligated to pursue. It would be even more difficult to achieve consensus about what functionings individuals should be morally obligated to act to achieve, and how they should be obligated to act to achieve them. This is, however, what SHG requires: enforcement of “shared moral norms” requiring individuals to act so as to maximize their own health.

Enforcement is the third practical problem that we identified for SHG’s protection of freedoms. Both punishment and social sanctions feature as enforcements in SHG, with “shared moral norms” internalized by “willing” individual subjects. In Foucauldian terms, shared moral norms become technologies of power; Ruger also wishes them to become technologies of the self (Foucault 1988). This is how SHG could lead to oppressive “healthism” (Rose 1999; Skrabanek 1994), impairing people’s opportunities to be who they want to be by enforcing health practices that may not be valued by all—or even by most. The everyday practices involved in improving or maintaining our own health—eating, exercising, feeling emotions, managing time, sleeping, and so on—do not merely constitute our health; they also constitute our identities. As currently presented, SHG seeks to govern these identity-constituting practices and oblige conformity to standards for action. Such obligations could undermine important substantive freedoms and have serious moral consequences. In particular, people could plausibly be designated morally inferior, sanctioned or punished if they chose not to conform to health advice: for example, about diet, physical activity, or consumption of medications.

We do not think the solution lies in radical individualism. We agree with Ruger and many others that to advance capabilities for health we need collective engagement and action. This is consistent with a capabilities approach, which is not isolationist and does not rely on ontological or methodological
individualism (Robeyns 2008). Capabilities bring responsibilities (Sen 2009): Cooperation and concern for the interests of others are necessary for their widespread promotion. We believe, however, that extending SHG as far as the lifestyles of individuals creates important conflicts with a capabilities approach. The capabilities approach entails normative individualism. It seeks to support valued capabilities and allow individuals to pursue those they value. It equates true development with establishing the circumstances that will allow these capabilities to flourish.

We thus argue that the capabilities approach does not clearly support the form of normative collectivism proposed in SHG. In SHG, the values of individuals, including values relating primarily to the minutiae of their own lives, are subsumed under the moral norms of an underspecified collective. The danger of generating a culture of oppressive “healthism”—whether by state enforcement or subject self-surveillance—seems high in the current formulation of SHG. To promote justice in health, we suggest that the scope of application of SHG should be reduced to governing macro- and meso-level services and systems. If this were done, SHG would be more likely to support capabilities for practices that enhance health without oppressively enforcing their achievement in individual subjects.

REFERENCES


