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CHOOSING HEALTH, CONSTRAINED CHOICES

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ABSTRACT

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In parallel with the neo-liberal retrenchment of the welfarist state, an increasing emphasis on the responsibility of individuals in managing their own affairs and their well-being has been evident. In the health arena for instance, this was a major theme permeating the UK government's White Paper *Choosing Health: Making Healthy Choices Easier (2004)*, which appealed to an ethos of autonomy and self-actualization through activity and consumption which merited esteem. As a counterpoint to this growing trend of *informed responsibilization, constrained choices (constrained agency)* provides a useful framework for a judicious balance and sense of proportion between an individual behavioral focus and a focus on societal, systemic, and structural determinants of health and well-being. *Constrained choices* is also a conceptual bridge between *responsibilization* and *population health* within an integrative biosocial perspective one might refer to as the social ecology of health and disease.

KEYWORDS: health promotion, gender, health behaviors, responsibilization, population health, social determinants

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1. INSTRUMENTALIZING AUTONOMY

How does a state exercise power in a neo-liberal context? Nikolas Rose and his colleagues have written extensively on "advanced liberalism", developing and extending Foucault's concepts of governmentality *(rationalities of governing)* to the exercise of (state) power in a neo-liberal context, which allegedly had evolved more diffuse modalities along with the retrenchment of the (Keynesian welfare) state:

> *it is possible to differentiate the exercise of power in the form of government from simple domination. To dominate is to ignore or to attempt to crush the capacity for action of the dominated. But to govern is to recognize that capacity for action and to adjust oneself to it. This entails trying to understand what mobilizes the domains or entities to be governed: to govern, one must act upon these forces, instrumentalize them in order to shape actions, processes and outcomes in desired directions. Hence, when it comes to governing human beings, to govern is to presuppose the freedom of the governed. To govern humans is not to crush their capacity to act, but to acknowledge it and to utilize it for one's own objectives*[1]

In the post-911 aftermath and indeed earlier, it was far from clear that the coercive power of the state was in retreat, even as the retrenchment of the *welfarist state*[2] continued without pause. Massive state intervention, to rescue imprudent *investment* banks, insurance companies and other financial intermediaries for the benefit of risk-taking investors, as opposed to depositors in a commercial bank (not to mention individuals and households suffering from the "collateral damage" inflicted upon the real economy by an escalating financial crisis), seems more akin to corporate welfare, for those unimpressed by invocations of systemic risk.

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[1] Nikolas Rose. 1999. *Powers of Freedom*: *Reframing political thought.* New York: Cambridge University Press. (p.4)

[2] I use the term *welfarist state* (a looser term) to distinguish it from welfare states, which have formal entitlement schemes of varying degrees of coverage for employment security, health security, retirement and elderly security etc (best typified by Nordic-type social democratic systems). With or without formal entitlements, most modern states (are expected to) play a role in coping with uncertainty faced by their citizens, whether arising from social, natural, or created environments. This risk pooling function (to reduce welfare insecurity) I call the welfarist aspect of modern states, one of the composite aspects that modern states can express - developmentalist, corporatist, regulatory and coercive, repressive, militarist, social-reproductionist, etc.

2. RESPONSIBILIZED CONSUMERS – THE NEOLIBERAL PARADIGM

In parallel with the neo-liberal retrenchment of the Keynesian welfarist state, Rose notes instead

> *[an] increasing emphasis on the responsibility of individuals to manage their own affairs, to secure their own security with a prudential eye on the future. Nowhere have these been more telling than in the field of health, where patients are increasingly urged to become active and responsible consumers of medical services and products ranging from pharmaceuticals to reproductive technologies and genetic tests. This complex of marketization, autonomization, and responsibilization gives a particular character to the contemporary politics of life in advanced liberal democracies*[3].

This was clearly a major theme permeating the UK government's White Paper *Choosing Health: Making Healthy Choices Easier* [4] which appeared in 2004.

The subtitle might have raised expectations of an extended discussion of the enabling environment for healthy choices, in its multifarious aspects - social, cultural, political, economic, ecological. But the promise was more than the delivery. Perfunctory introductory remarks by the Prime Minister and the Health Secretary were quickly followed by a focus on the responsibility of the state to provide and to disseminate the knowledge base for informed choices, to reconcile the potential conflicts arising from choices among individuals (one individual's choice may impact adversely on the well-being of another), and to attend to the needs of the young who have yet to attain an adult capacity for meaningful, informed choice:

> *These considerations, therefore, run through this White Paper: helping people to make healthier choices for themselves; protecting people's health from the actions of others; and recognising the particular needs and the importance of emotional and physical development of the young. Government cannot simply leave it up to individuals, we must work with others to provide collective support to help create an environment which promotes health. These form the basis of achieving a balance between the healthy outcomes we all want to see and the equally valued freedom to determine our own way of life that is so important in a democratic society. (preface, John Reid, UK Health Secretary)*

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[3] Nikolas Rose. 2006. *The Politics of Life Itself: Biomedicine, power, and subjectivity in the twenty-first century*. Princeton, NJ: Princeton University Press. (p.4)

[4] *Choosing Health: Making Healthy Choices Easier.* UK Department of Health, 2004.

It was in this context that the recent publication by Chloe Bird and Patricia Rieker, *Gender and Health: The Effects of Constrained Choices and Social Policies* [5] took on added significance.

The subtitle in particular suggested a counterpoint to this growing trend of *informed responsibilization,* couched in terms which appealed to an ethos of autonomy and self-actualization through activity and consumption which merited esteem. Hovering in the background meanwhile was the more substantive threat of withdrawal of entitlements and services for those deemed to be irresponsible in their chosen lifestyles, or to have violated norms of responsible citizenship in their health behaviors.

Bird and Rieker did not in the first instance set out to dissect neoliberal rationalities of government, nor to develop a response to it. Their point of departure, as indicated by the book title, was first and foremost gendered differences in health status, which they argued were not adequately explained by resort to biological or sociological approaches, nor even to certain integrative biosocial perspectives.

What singled out Bird and Rieker's approach as a corrective or counterpoint to *responsibilization* was their claim that (gender-) constrained human agency might be more relevant to explaining health disparities between men and women, within an integrative biosocial perspective on human health:

> *Our approach draws upon the prevailing [sic] public health understanding of health disparities, which emphasizes the role of personal choices and health behaviors in enhancing or diminishing an individual's ability to live a long and healthy life. We argue that men's and women's opportunities and choices are to a certain extent constrained by decisions and actions taken by families, employers, communities, and governmental policies. In the long run, these choices can contribute to the observed patterns of gender-based health differences by creating, maintaining, or exacerbating underlying biological differences in health. (p.5)*

They might have also mentioned systemic (structural) constraints such as the monetarist obsessions of globally mobile finance with fiscal deficits and balanced budgets, which impacted not merely on individuals but constrained the leeway available to governments in their social expenditures on health, education, and other public amenities, along with associated gendered impacts of these fiscal regimes[6].

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[5] Chloe E. Bird & Patricia P. Rieker, 2008. *Gender and Health: The Effects of Constrained Choices and Social Policies.* New York, NY: Cambridge University Press.

[6] Paloma de Villota (ed.). 2004. *Economics and Gender: Macroeconomics, Fiscal Policy and Liberalization: An Analysis of Their Impact on Women.* New York: UNIFEM.

3. CONSTRAINED CHOICES: BETWEEN RESPONSIBILIZATION AND POPULATION HEALTH

> *… almost every penny that these women spend is for someone else, for the household, the children, the boyfriend. The only personal expenditure they allow themselves is cigarettes. Without that indulgence, the whole of life would be about keeping it together for others. Simple exhortations not to smoke are unlikely to have much impact on these low-status women, and men. Improving their social conditions might.*
>
> Michael Marmot[7], citing Hilary Graham's observational studies of the lives of low-income working women[8].

Bird and Rieker's focus on individual human agency is in keeping with a behavioral emphasis in US public health practice, expressed for instance in the definition of health promotion adopted by the American Journal of Health Promotion: *"Health promotion is the science and art of helping people change their lifestyle to move toward a state of optimal health".* www.healthpromotionjournal.com/

For health professionals in the field of preventive health, this "patient-centered" focus on the individual (if not on individual lifestyle) has prompted Barbara Starfield and her colleagues to express unease over the evolving meaning of *prevention*[9], as its focus has shifted over time from public health (a population orientation) to clinical (pre-)disease and preventive care (an individual focus)[10].

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[7] Michael Marmot. 2004. *The Status Syndrome: How Social Standing Affects Our Health and Longevity.* London: Bloomsbury Publishing.

[8] Hilary Graham. 1993. *Hardship and Health in Women's Lives.* London: Harvester Wheatsheaf

[9] *"…perhaps the biggest threat to the concept of* ***prevention*** *is the progressive lowering of thresholds for ''pre-disease'', particularly hypertension, serum cholesterol and blood sugar… [where] risk factors are increasingly considered as equivalent to disease… Encouraged by interests vested in selling more medications for ''prevention'' and more medical devices for testing, the pressure for increasing ''prevention'' in clinical care directed at individuals is inexorable - even though it is not well supported by evidence in populations of patients…"* B Starfield, J Hyde, J Ge´rvas, I Heath. 2008. The concept of prevention: a good idea gone astray? *J Epidemiol Community Health 62:580–583.*

[10] This individual focus received an added boost with the completion of the sequencing of the human genome in 2000 (in its draft form), which provided the occasion for extravagant claims for genomics as an all-round panacea for the major health (and social) problems of humanity in the 21st century. Notwithstanding this *genohype*, there has been limited success thus far with gene-based therapies, and few promising candidates on the horizon. Commercial interest is thus likely to shift towards genetic testing for "disease susceptibility" alleles in line with a "paradigm shift" towards "predictive medicine" (genetic profiling of individuals for assessing risk of future illnesses). This has the added attraction that mass markets are involved, since the genetic testing for "disease susceptibility" may be applied in a routine manner as part of well-person (or well-child) care and screening. Accompanying this almost certainly will be corporate R&D aimed at producing "pills for the healthy ill" (the worried well) to carve out sizeable new markets not just for screening tests but also for "prophylactics" for those deemed to be "at risk" and consequently anxious for the availability of some (commodifiable) risk reduction options.

In contrast to this, population health strategies, according to the Federal, Provincial & Territorial Advisory Committee on Population Health of Canada *"address the entire range of factors that determine health, in contrast to traditional health care which focuses on risks and clinical factors related to particular diseases. Population health strategies furthermore are designed to affect the entire population, rather than individuals one at a time who already have a health problem or are at significant risk of developing one"*[11].

The Ottawa Charter for Health Promotion (1986) famously stated that *"health promotion focuses on achieving equity in health…and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. The fundamental conditions and resources for health … [which] apply equally to women and men… are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity."*

Notwithstanding this, Dennis Raphael has lamented that even in Canada, health promotion has been gradually reduced in practice to lifestyle issues largely focused on "the holy trinity of tobacco use, diet, and physical activity", which he attributes to Canada's joining the UK, USA, New Zealand and Australia in a neoliberal resurgence in public policy approaches in the last two decades[12].

In 2005, Hurricane Katrina revealed the decrepit state of under-funded and degraded public agencies in the US for disaster response. In its aftermath, *"Americans were reminded that risk is an integral element of everyday life. Natural disasters are a magnifying glass into popular perceptions of fate and responsibility, and it became clear that most Americans - for all their faith in individualism and personal responsibility - believe that some risks should be viewed as a common problem that can only be effectively addressed through broad cooperative policies of insurance and assistance"*[13].

Some argue that the ongoing financial crisis with its escalating damage to the real economy and distress for individuals and households, and the unavoidable state responses needed to mitigate these effects will reinforce an appreciation of the systemic character of this crisis (imbalances between accumulation and consumption, systemic tendencies towards stagnation), going beyond simply "greed", "misaligned incentives", and institutional regulatory failure[14].

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[11] *Strategies for Population Health: Investing in the Health of Canadians*. Federal, Provincial & Territorial Advisory Committee on Population Health, 1994 www.phac-aspc.gc.ca/ph-sp/phdd/pdf/e_strateg.pdf

[12] Dennis Raphael. 2008. Getting serious about the social determinants of health: new directions for public health workers. *Promotion & Education 15:15-20.*

[13] Jacob Hacker. 2006. The Privatization of Risk and the Growing Economic Insecurity of Americans http://privatizationofrisk.ssrc.org/Hacker/printable.html *(posted on June 7, 2006; accessed on February 25, 2008)*

[14] John Bellamy Foster & Fred Magdoff. 2008. Financial Implosion and Stagnation: Back to the Real Economy. *Monthly Review, December 2008.*

Bird and Rieker's publication is a timely, modest step towards regaining a sense of proportion between an individual behavioral focus and a focus on societal, systemic, and structural determinants of health and well-being. The conceptual framework and arguments they have presented, drawing upon earlier work which they have acknowledged[15] and which others have pointed out[16], have a generality that go beyond gender analyses of human health, indeed beyond individuals to social aggregations and institutions.

As a conceptual bridge between *responsibilization* and *population health, "constrained choices" (constrained agency)* is a useful framework that should be further developed and tested, embedded within an integrative perspective one might refer to as the social ecology of health and disease.

[15] *constrained choices* recalls the notion of *bounded rationality* introduced by Herbert Simon, which more specifically dealt with cost constraints of information gathering and processing, for purposes of decision making.
[16] reviews of Bird & Rieker in 2008, by Sana Loue in *New Engl J Med 359(11):1187* and by Laurence McCullough in *JAMA 300(8):968.*